

CORRESPONDENCE

The times they are a-changin: implementing new psychiatric rehabilitation models within a community care in the post COVID-19 era

Lorenzo Pelizza¹, Simona Pupo²

¹Department of Mental Health and Pathological Addiction, Azienda USL di Parma, Parma, Italy; ²Anesthesia and Resuscitation Service, Azienda Ospedaliero-Universitaria di Parma, Parma, Italy.

To the Editor,

As of November 30, the COVID-19 epidemic resulted in more than 50 000 deaths and 1.50 million confirmed cases. From the early stages of the pandemic, community medical interventions played a key role against the infection spreading and as first-line treatments to avoid hospitalization (1). For the public mental health policy in Italy, “the person as a community resource” has traditionally been a central point within a post-institutional psychiatric care model, aimed at combining the individual unmet needs with a care responsibility of the native community (i.e. family members, health and social services) (2). The COVID-19 pandemic contributed to revive a “community-centered” mental healthcare system, together with the supremacy of public health interventions over the private ones (3). For this new, comprehensive “proximity welfare”, people with mental disorders are not isolated at home, but continuously connected with their community services, also supported with “telepsychiatry” and modern, “in vivo” rehabilitation interventions (e.g. Individual Placement and Support [IPS] and Personal Health Budget [PHB]) (4).

(A) The PHB is a contract-like, commitment agreement between the patient, her/his family and the healthcare/social agencies involved in her/his care pathway. As a crucial part of the “Individual Therapeutic-Rehabilitation Plan” (ITRP), it consists in cumulative person-centered funds aimed at supporting personal unmet needs, at improving patient’s functional and clinical recovery and at implementing

her/his active participation and social inclusion in the native community (5). PHB may be directly offered as monetary payment/support or (like in Italy) mainly provided via “indirect budget”, made available to the patient by third parties (e.g. social agencies, family members and/or healthcare services) (6). Specifically, PHB has been developed to allow patient’s discharge from psychiatric facilities into her/his community environment (rehabilitation purpose) or to delay/avoid patient’s new admissions (preventive purpose). However, PHB has over time gained more ambitious aims: in particular, it should be intended to plan and support person-tailored healthcare pathways, maintaining the patient at home and struggling against stigma and her/his social isolation (5).

The qualifying elements of the PHB model in Italy are: (a) a person-centered, recovery-oriented ITRP, based on an in-depth assessment of the individual wishes and unmet needs, and (b) a “Multidimensional Evaluation Unit” (including the patient, her/his family members, mental health and social services), specifically aimed at defining both the ITRP and the PHB resources (5). The ITRP is intended to offer specialized rehabilitation interventions within the areas most affecting people’s health: (a) “housing” (through actions supporting life at home or gaining new home/accommodation), (b) “job” (through training activities and supported employment), and (c) “sociality” (through actions promoting friendship and social networks, and/or improving individual social skills) (6). The PHB resources can be jointly provided by: (a)

community mental healthcare services (rehabilitation intervention, often relying on social cooperatives), (b) local social agencies (e.g. through social workers, meals at home, public housing, financial aids); (c) the patient and her/his family members (with their both economic and relational resources), and (d) local voluntary associations (5).

(B) The *IPS* is an evidence-based psychosocial intervention to help people with mental illness in obtaining and maintaining competitive jobs in the open labor market (4). It showed to be more effective than other traditional vocational rehabilitation models (e.g. training stages or sheltered workshops offered by social cooperatives), which are flexible and sometimes rapid instruments, but are also quite stigmatizing and overprotective, as well as often keep the patient out of competitive labor market for a long time (7). Indeed, the *IPS* model is based on the following core principles: (a) focus on competitive employment in the open job market, (b) support in a rapid, active job search (without lengthy pre-employment training), (c) integration of local job agencies with mental health services, (d) person-tailored job support, mainly based on her/his job preferences, (e) time-unlimited support, and (f) eligibility based on patient's choice (i.e. motivation is the most important condition for the *IPS* recruitment) (4). *IPS* specialists support the patient by rapidly searching for vacant jobs and by coaching her/him in working situations. Once employed, "on the job" training and follow-along support are offered to help the subject in maintaining job for as long as possible. Indeed, *IPS* specialists offered time-unlimited support (i.e. before, during, and after employment periods), together with mental health service team.

In conclusion, the COVID-19 epidemic has helped to enhance the importance of building a dynamic bridge between "patient-centered" and "community-centered" welfare systems. However, times are changing now and the epidemic wave is about to run out. In the post COVID-19 era, *PHB* and *IPS* intervention models may represent two innovative, integrated psychosocial instruments aimed at placing the patient in her/his life environment while giving her/

him a sense of self-agency in planning her/his life project and healthcare pathway. They can also be clinically useful in addressing the hot issue of social isolation and unmet social needs within the patient's belonging community.

Conflicts of interest: Each author declares that he or she has no commercial associations (e.g. consultancies, stock ownership, equity interest, patent/licensing arrangement etc.) that might pose a conflict of interest in connection with the submitted article.

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Correspondence:

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Lorenzo Pelizza c/o Centro "Santi" - Via Vasari n.13 - 43100 Parma (PR) - Italy; Telephone number: +39 - 0521/396502; Fax number: +39 - 0521/293482; e-mail: lorpelizza@ausl.pr.it