1st International Meeting- Franco Basaglia: La Comunità Possibile
Trieste, September 1998
RECOMMENDATIONS OF THE "PRACTICES" STREAM COMMISSIONS
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No form of community mental health care is possible without the elimination of psychiatric hospitals of any type or size, given that such institutions remain the primary location for the reproduction of psychiatry and the dehumanisation, exclusion and impoverishment of persons who suffer. The task of, their elimination should spread from Italy until it acquires a global dimension, thereby both declaring and realising the end of the asylum century.
There are several fundamental indicators for this drive to create a community-based practice:

- No coercion
- No constriction
- No practices which violate the body
- No confinement
- No incarceration.

The *Practices* Stream of the Trieste 1st lnternational Mental Health Conference set forth the following goals:

- The need to create community services which are integrated, coherent and capable of developing a strategy which responds to the mental health needs of a given community.
- In order to achieve this goal, the fundamental starting-point remains a deinstitutionalisation which aims at superseding not only the psychiatric hospital but also the current psychiatric practice of "treating and curing illness".
- The fragmentation of specific responses for specific needs and individuals should be avoided. This only reproduces separation and objectification based on categories and ideologies of exclusion.

More specifically, the following are the basic principals and pre-suppositions indispensable for any practice intended to produce mental health:

1) Breaking the medical paradigm, which totalises, and reconstructing and endowing individual life-stories with value;

2) The possibility of illness expressing itself as suffering within the various areas of a person's life and a therapeutic approach which takes the whole individual into account and which recognises his uniqueness;

3) Affirming the protection of rights as the fundamental element in the treatment of an ill individual.

The community service must represent the central strategic-organisational moment in the production of prevention, treatment and rehabilitation practices understood as a unified mental health issue.

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Its organisation should be based on:

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- Co-ordination between the different parts of the service network in order to guarantee therapeutic continuity;

- The accessibility of the service which should be re-evaluated and redesigned based on user needs;

- Programs which are flexible and modulated as opposed to rigid protocols;

- The non-selection of users based on the seriousness of their condition;

- The integration of useful resources in order to respond to the material and relational needs of individuals;

- Avoiding hospitalisation through the development of community crisis interventions;

- Confronting the most difficult situations with the highest content of personal and social suffering within the community itself, and thus the non-delegation of such situations to institutionalisation and containment structures both old and new.

Services must shift from a clinical model based on the illness-symptom to one which is overall in its vision and approach and which is based on "shouldering the burden", or assuming total responsibility for all the user's needs and meanings. Mental health practices must involve actors, resources and social processes which go beyond the psychiatric operators to include the users themselves, the members of the social network and the community network.
The new miliennium will see the decisive development of the role of nonprofessionals in strategies of assistance and social reintegration.
However, the struggle must continue so that services worldwide can be guaranteed adequate human and material resources, whether through local means or international aid.

Services must be conceived as realities in evolution, open to change, both responsive to and interacting with new needs as they emerge from society. They must also be able to identify and overcome new forms of institutionalism.

In the shift from psychiatric institutions which are regulated, segregative and oppressive, to community organisations made up of agents of mental health, of men and woman who, in that capacity, are able to provide services to individuals, the nature of the community service organisation is of fundamental importance in the ability to develop strategies of health and support for persons in need. It remains a primary indicator for measuring the degree of anti-institutional "tension" and it must be relational, horizontal and transversal in nature. The establishment and definition of procedures and the service's planning should involve the active participation of all the operators at all levels. The service's "vision", its intentions and its system of values in social and therapeutic terms must always and invariably be based on the central importance of the primary user and his process of recovery, his "comeback", and his existential possibilities.

The organisational work must therefore connect structures and programs. It must not allow them to remain in separate contexts but articulate them into pathways which permit the user to make choices of opportunity.

The concept of community responsibility for mental health must also be able to redefine the mandate of social control. Such redefinition must take into account and mediate between the points of views of all those involved, but always with the protection of weak and vulnerable subjects as the top priority.

De-stigmatisation should be carried out not only in the sense of overcoming the medical paradigm, but also by expanding forms of access to and participation in the life of the service, from planning to management, for everyone involved. These forms can include committees and consultation groups made up of users, operators and ordinary people in the community.

The service should network with other social-health services. The health districts, the community medical services and Primary Care should be modulated with a view to maximum accessibility.

It is also necessary to "contaminate" the entire social-health network in terms of deinstitutionalisation and, in the movement towards the formulation of overall health projects, to "de-medicalise" wherever possible.

The keystone of the community mental health system is the 24 hr mental health centre, open to the community, or any other form of integrated 24 hr service organisation which does not include conditions of medium or long term psychiatric hospitalisation and which, in fact, is oriented towards overcoming forms of short-term stays in a medical environment.

Small-scale reception centres should be provided for which are not clinical but based on the real situations of daily life. They should have flexible time periods, be adjustable to individual needs, and be able to sustain and develop the capacity for self-management and experiences of participation within the community.

The right to live in one's own private space, regardless of the seriousness of the disturbance, should also be guaranteed, thereby avoiding the risk of new forms of the asylum and institutionalisation, of exclusion and objectification.

The right to have a productive, or at least an active, role within society through job placement or forms of social enterprise, should also be guaranteed.

The services must recognise differences of gender, race and culture as fundamental to the concept of equal rights and as forming the basis for health practices.

Programs should be viewed from the perspective of an integration between various kinds of interventions, as opposed to models which are sectorial or based on technicism or which are

simply some sort of eclectic sum, and which always identify their own failures as "residual", to be excluded once again.

The avoidance of approaches which are pre-fabricated and which result in standardisation, and guaranteeing that it is the uniqueness of the individual and the construction of his own existential meaning which guides the action of treatment can only occur if one begins from the user's active involvement in his own therapeutic project, recognising in him an effective contractuality and power.

The differences between contexts, locations and individuals as materials and resources for therapeutic action must be enhanced.

It is therefore not treatment models which are needed, but integrated projects for mental health and health in general (meaning also "social" well-being). Such projects must take into account institutional situations but cannot be applied within total institutions, otherwise they risk being perverted into strategies of mystification, of false rehabilitation and of consensus management.

The separation or opposition between places of therapeutic and rehabilitative treatment must be overcome, to the extent that they are seen as components of a reparative medical model. Instead, they should be considered in terms of context and synergy.

It must be recognised that individual crisis invariably contains a nucleus of meaning and conflict, of potential and risks. Crisis should therefore not be considered as something to be contained or silenced. Instead, its central role in the service's practices should be directed towards avoiding stigmatisation and stopping the "assembling" of illness, to the degree that such illness is a social and institutional product.

"Creating a community" should be of prime importance in the operations and planning of community services. Such services must be able to produce networks and to work with networks which already exist. Particular attention must be given to primary networks (family, neighbours, friends, the workplace). Attention must also be given to formal or official networks, that is, the health and social services, with whom networking must occur. Finally, artificial networks, or networks of networks, must also be promoted through an effort of connection, which should include associations and any group situation, both inside and outside of the field of mental health.

Networking should not be seen as an alternative to the work of building services. It therefore has nothing to do with cutting expenses, with the absolute lack of resources for services, or with the development of strategies external to the official services, though these are both possible and desirable.

It is instead concerned with recognising in a very real way the insurmountable limits of welfare and assistance systems. It is a way of preventing policies from being dictated from above without taking into account the role of individual human beings, their interests, their values and their ideologies.

Networks which result from this approach become vehicles for values and empowerment, and should be seen as mobile, equal and horizontal organisations which are composed of individuals around shared goals.

The service must function as an interface with the territory/community.
In order to achieve this aim, a number of basic actions are necessary:

- Participation/entry into the services must be encouraged for everyone the service encounters, whether they are organised or exist in associated forms or not;

- Users should be involved in the services through aggregation, the promotion of self- and mutual-help, relationships with associations, and forms of consultation and participation in decision-making as forms of empowerment. At the same time, these actions are not sufficient in themselves and must include or be premised on the availability of real resources and the ability to use and profit from them through strategies of citizenship training and information;

- Non-professional and "extra-clinical" resources must be utilised, not only in the therapeutic-rehabilitative work but also in community mental health projects;

- Community health should be promoted by both encouraging the social integration of users and stimulating the awareness of ordinary people with regard to the problems of mental health, and by planning for "2-way" forms of exchange with the community;

- Practices of inclusion and belonging should be encouraged which support and sustain the construction of identity and of multiple social roles, and which do not oppress the primary user in his role as such but support his uniqueness as an individual;

- All forms of collective and participatory action which involve an affective dimension through reciprocity and the overcoming of limits of institutional roles should be sought out and encouraged;

- Educational and "empowerment" strategies should be seen as the building of autonomy and the reduction of social barriers which impede the exercise of the full rights of citizenship;

- The recognition and strengthening of networks should also be carried out in order to help in the transformation of the service and to accelerate the anti-institutional work;

- The service must actively and reciprocally intervene in the culture of the community with regard to mental health and with the intention of overcoming social exclusion.

  By means of such actions, tolerance need no longer remain a paternalistic concept, but can become the goal for real processes of social inclusion.