

**1st Trieste International Congress for Mental Health -
"Franco Basaglia la comunità possibile"**

Report on Trieste

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This report follows my visit to the 1st International Congress in Trieste, 20 - 24 October, 1998 where I presented two papers. It is based upon proceedings of the Conference, information provided by Dr's Roberto Mezzina and Guiseppe Dell'Acqua, and my own opinions formed during the visit.

An introduction to Mental Health Services in Trieste

Trieste is situated on the borders of Slovenia and Croatia and a corner of the Adriatic Sea. It has had quite a tumultuous recent history. It was ruled by Austria until the end of World War 1, by Italy until its defeat in World War 2, by the Allies through the British Army until 1954, and then again by Italy. While Trieste is not regarded as a depressed area, it does face serious economic problems. A key problem in Trieste in particular is unemployment. Unemployment currently runs at 14%. The economic recovery of the city has been a priority with much effort going into trying to encourage industry, commerce and entrepreneurs to establish in Trieste.

Trieste is however, a bustling city which, while not a mainstream tourist destination, holds much to attract the visitor and many hidden treasures confirming a history which dates back to 52BC. It also boasts a busy port providing a regular ferry connection to Greece, a typically balmy Mediterranean climate, the oldest population in Italy, a large Slovenian minority, and a unique mental health service.

The present mental health service system in Trieste is in no small way accredited to the work of Franco Basaglia, particularly in the early 1970s. In 1971 the psychiatric hospital in Trieste had 1200 patients. In 1974 the doors to the hospital were unlocked, allowing patients to come and go as they wished. This was celebrated quite symbolically by the destruction of the wall separating the hospital from the town, and by a public procession of patients and staff with an 8 foot high, blue, papier-mache horse. This horse has now become a symbol of the revolutionary model of mental health services now provided in Trieste, and was also the logo for the Conference. It is worth noting that the work of Basaglia is well known and recognised in the city; the blue horse was on display in the main square for much of the Conference and posters promoting the Conference were also prominent.

Basaglia regarded the scientific dominance of psychiatry with concern and skepticism. According to Basaglia, science had become regarded, in this Century in particular, as an instrument of wealth and well-being. More pertinent to our professions, it has also been used to confirm the "inferiority", and justification for the

exclusion of people as social outcasts. Taken to its extreme, traditional psychiatric practice represented a form of therapeutic nihilism. Basaglia is described as a man who interrupted the ritual nature of knowledge and reinforced the contradictory nature of life (and so people). It is these contradictions which science (and so psychiatry) attempts to deny.

The mental health system consists of six mental health centres (five of them with eight beds each), an eight bed emergency unit in the general hospital, group homes, work cooperatives, a woman's space and a social club for young people. There are virtually no "not-for-profit", NGO type organisations in Trieste. Each Mental Health Centre consists of psychiatrists, psychologists, nurses and social workers and volunteers. Occupational therapy does not exist as a profession in Italy. Each Centre has to respond to all requests for mental health provision (not just "serious" mental illness/distress) in its catchment area of around 50,000 people. Each centre serves around 3000 people per year.

Probably the most remarkable statistic is the very low rate of compulsory admissions. Between a period 1978 to 1988 there were only sixty four such admissions; in some of those years they were actually none. These statistics reflect a fundamental assumption underlying the development of services in Trieste: psychiatric hospitals are bad for psychiatric treatment.

By comparison with the usual models of provision of mental health services in New Zealand, the services in Trieste provide examples of a number of quite radical departures:

- apart from the eight beds at each of the mental health centres (for short term, respite-type use), the service functions with only eight emergency beds located at the general hospital
- the beds available in the mental health centres offer asylum in the community. They remain an open facility even for those who come in under the rules of compulsory admission
- the work of the mental health centres is articulated through a wide variety of structures; while these may be differentiated in terms of their functions, they are highly integrated with each other and with the community
- the multidisciplinary teams comprise, doctors, psychologists, nurses, social workers, sociologists and volunteers; again these are integrated with other professionals and social services in the city
- access to services is available 24 hours per day, 7 days per week
- each centre is responsible for the mental health needs of the whole district population
- all facilities remain open; ie. there are no physical, structural or service restraints in place - even for people who enter under the rules of compulsory admission

To appreciate the genesis and development of contemporary mental health services in Trieste they should be regarded as a consequence of a revolution. This revolution was led by Basaglia, his supporters and their vision. By contrast New Zealand (like most other countries) has adopted a slower, more considered process of evolution.

The principle medium for providing vocational services in Trieste is through work cooperatives. The cooperatives create jobs and enterprises that compete on the open market. These employ close to 300 people – not all with a history of mental illness. With unemployment so high in Trieste the cooperatives are also regarded as an attractive option for many “non-disabled” unemployed. All workers receive award wages.

Enterprises the cooperatives are involved in include: running a hotel, a restaurant, a bar, a commercial radio station, construction, video production, various farming and horticultural activities and various service/maintenance work.

The Conference

The Conference attracted around 700 delegates from around the world. Their stamina and commitment certainly matched that of our hosts; each day’s proceedings began at 8.30am and concluded at 7.00pm. Most people were still in attendance at 7.00pm!

Much of the Conference was devoted to presentations which described and celebrated the nature and success of services such as those provided in Trieste. A lot of discussion at the Conference focussed upon philosophical values, the politics of power and exclusion/inclusion, and some quite intense epistemological discussion. The issues raised by these discussions provide for a rich discourse. Owing to ideological beliefs appears to be considered more an honoured and integral fact of life, rather than reflective of an "unethical" professional. Clearly it is seen as unethical to provide psychiatry as simply a set of technical practices and exercise of expertise.

There appears to be a greater tolerance of difference in Trieste. This seems to be reflected in service provision through a great emphasis upon recognising the complexity of life and individuals, and so avoiding any attempt to apply (or even impose) a simplistic interpretation or diagnosis related to medical thinking. Thus the obsession with seeking and applying [simple] solutions to problems (ie. identify the problem then fix it) is hopefully avoided.

A significant difference was the nature of the relationship between the "patient" and the professional. There seemed to be a greater willingness and ability on the part of mental health professionals to invest their "selves" in the relationship with clients. This investment was an important component of any interventions and consistent with the philosophical under-pining of promoting "inclusion" as opposed to "exclusion". ("we do nothing for you; we do everything with you", was a motto I heard from one professional). Assessment and treatment is provided principally in a person’s home; all assessments being based on needs instead of diagnosis.

While remaining "professional", the notion of objectivity was clearly regarded as a myth. Services focus entirely upon the person’s own subjectivity, building upon their

experiences and strengths and aiming to promote a sense of responsibility and ownership. Further, through all interventions the aim is to endow the person with rights; the "therapeutic" value of freedom was highlighted a number of times. More importantly "how to exercise" that freedom is seen as a core objective of mental health services; such services focus on being emancipatory.

Needless to say, in Trieste there are no physical constraints; mental health services have an open door policy - and there is no ECT.

With respect to crises, these are very much regarded in terms of powerful "opportunities"; a "prime engine for change and transformation". They are, it was noted, usually responded to in terms of "intervention philosophies which immediately classify the crisis according to restrictive medical-psychological which aim at containing and controlling it". The point at which a person in crisis usually receives attention was regarded as the point where the greatest simplification of interventions occurs. Instead, it was argued, the full context of the individual's environment needs to be taken into consideration and, if necessary, brought into focus as a more effective response to an individual "crisis". A common concern from those people who remain doubtful about the effectiveness of deinstitutionalisation is the apparent increase in emergencies and crises. It was noted however that these also occur in general medicine and are not necessarily reflective of the closing of psychiatric hospitals. It was further argued that they might also be the outcome of degrading social conditions, uncertainty of life, social despair etc.

A common theme throughout the conference was that psychiatric theory and practice are the products of institutional experience. If it is not able to transform and develop an ability to regularly adapt to the dynamic nature of, and issues inherent in, contemporary living, it will not survive outside the institution. Indeed one psychiatrist at the Conference remarked that "a good psychiatrist is somebody who works toward the end of psychiatry".

Institutional	Post-Institutional
Hospital	Community
Segregation	Integration
Invalidation	Meaning
Defined Roles	Question Practice
Diagnosis	Needs Assessment
Custody	Emancipation
Incarceration	Rights
Medical Discourse	Personal Discourse

It was clearly evident that the focus of services is not solely upon the mental illness; nor is the illness necessarily simplified into diagnostic categories and symptoms. A consistent theme presented by those providing services in Trieste was that traditional psychiatry is still based around exclusion. A consequence of this was the extreme marginalisation of people who are affected by a mental illness; people who effectively experienced a "double" exclusion - by the mental illness and then by psychiatry. A reductionist model of psychiatry still dominates psychiatric thought and, to all intents and purposes, tends to ignore the "person" as a human-being. Such

a reductionist model was described as being essentially ideological in that it is more linked to bias than it is to reality.

In a profession which I guess is greatly affected by variable staff morale, the staff of mental health services in Trieste demonstrate enthusiasm and a quite passionate belief and commitment to what they are doing, and appear to gain enormous satisfaction. In no small way this is due to their being perceived by many (and perceiving themselves) as being at the cutting edge of change. Service development is still perceived as a "movement", guided by charismatic leaders, and confirmed by a constant stream of overseas visitors and correspondence. The critics unite the team, while admirers encourage them on to greater things.

They hold a strong view that the community must accept responsibility for its own mental health problems and not hide and attempt to ignore the issues through segregation and exclusion. This is further encouraged by a real reluctance to support pleas in law of diminished responsibility - such a plea may only be partially accepted to a quite limited extent. One session of the conference involved presentations of the Mayors of Trieste, Levorno and Forma - two other nearby cities - and representatives from the Italian Parliament. (It was interesting to note that the Mayor of Forma is a psychiatrist!). They actually speak with pride and passion about their role in supporting mental health services in their cities. They spoke of the ethics of responsibility - one of the mayors defined psychiatry as a metaphor for the whole city and the need to care for everyone. They too, spoke of the exclusion and marginalisation of some population groups as a community problem which *they* share a responsibility to address.

Some visitors raised questions around the fact that it is a service which appears to be still dominated by professionals - certainly radically thinking (by our standards) professionals, but there was little evidence of how the community is represented as partners with an equal and key role. There was much mention of need to remove hierarchies; however there was always the impression that a clear hierarchy still existed. While consumers of services were clearly evident at the Congress, again the way in which the Congress came across was to present what "they" had achieved - particularly the vision of Franco Basaglia. The role of consumers in the process of development and current provision of services was less clear and not acknowledged to any great extent. However, as a contradiction, there was an incredibly powerful and effective series of role plays provided by a group consumers during breaks. These required no translation, so stark were the messages and presentations. These were performances from people who appeared fully aware of their rights - and their ability to exercise them - in continuing to challenge psychiatry in Trieste.

Conclusion

In Trieste, one is immediately struck by a service delivery model which appears to be acutely aware of the politics of mental health. By politics in this sense I'm not referring to matters of Government, but more to issues of power, freedom, and ideology. It was refreshing to hear such fascinating and considered discourse applied to the delivery of mental health services. What provided greater justification for the

arguments presented was that they were not just theoretical assertions, there was also evidence of genuine success of their application in practice.

A key lesson for us to take from Trieste is the form of discourse, analysis and reflection that has informed and continues to guide developments. I think this is particularly pertinent as we often hear about a need for changes in attitudes and values as well as challenges to existing paradigm in mental health service delivery. We probably also need to consider regularly the politics of New Zealand mental health services; the values that they impose/impart on service provision and the outcomes to be achieved.

For example, do we in this country need to focus more upon a notion of “social citizenship” as an outcome for people we are working alongside of; does this need to be made more explicit? Do we focus so much on “needs” that we lose sight of a person’s “rights”? Do we [unknowingly] support forms of social exclusion through a lack of commitment to the emancipation of people we work alongside of?

The key thing for us is the fact that such services have been achieved, quite radical innovations have been introduced and succeeded, and further developments are still happening. A lot of the content tended to be rhetorical, very esoteric philosophical debate with much rumination and agonising - but so passionate. In one of the more eloquent presentations, mental illness was described as a form of poetry. It speaks of love, life, separations, powerlessness, power, passion and poverty.... The fundamental problem with the mental health system is that it attacks the poem, rather than listening to the message.

I can't but help but think that this is a form of rich and critical discourse we need to adopt more in New Zealand. Service provision in Trieste, while providing much to emulate, may not be a model that can be readily transplanted in total to New Zealand. However, it does provide evidence that many assumptions and “givens” in our service provision, can and should at the very least be debated - if not challenged.

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