PSYCHIATRIC REFORM IN ITALY

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The process for the reform of public psychiatric assistance which has taken place in Italy over the last 30 years has resulted in the transition from an asylum psychiatry based on exclusion and internment to a community mental health work-style based on inclusion and the restoration and construction of rights for persons affected with mental disorders. The transition from the psychiatric law of 1904 - which defined the mentally ill person as "a danger to himself and others" and "a public scandal" and which organised the institution of the asylum around this danger in order to treat/contain it – to the reform law, Law 180 in 1978, which sanctioned for the person affected with mental illness the right to voluntary care in the community, not only marks a legal but a conceptual-practical transition as well. And it does so by denying the equivalence mental illness-social danger, giving the mentally ill person access to social citizenship and prohibiting the construction of new psychiatric hospitals.

The Italian experience can be seen as a theoretical-practical process of deinstitutionalisation which begins with the asylum in order to move on to the deconstruction of psychiatry and illness.

Deinstitutionalisation, as distinct from de-hospitalisation (or the mere release of patients from psychiatric hospitals), is a process for the theoretical-practical criticism of the legal, administrative and scientific apparatuses which sustain the asylum. These apparatuses were created and developed around the idea of illness-as-danger, a concept which is artificially abstract and detached from the overall existence of the individual and of society in general.

Deinstitutionalisation is the "critical-practical process which reorients institutions and services, energies and knowledge, strategies and interventions" from the artificial object illness to the "patient's existence-suffering and his relations within society as a whole" (Rotelli, 1990).

Deinstitutionalisation is a practical process for the deconstruction and shutting-down of psychiatric hospitals and the construction of a network of community services capable of meeting the mental health needs of a given community and promoting personal and group itineraries for health and social emancipation.

In that absurd and inhuman institution which is the psychiatric hospital, "the ill individual does not exist (even though he is the ostensible purpose of the entire institution) stuck as he is in a passive role which both codifies and cancels him out" (Basaglia, 1967). Internment robs him of his civil and political rights, deprives him of freedom and power, as well as social exchanges, relations and roles so that, with the denial of any identity beyond that provided by the illness, he remains the object of guardianship and violence.

In deinstitutionalisation, it is the mentally ill person who is at the centre of the process, in all his complexity and uniqueness, so that he can become an active participant in his care and rehabilitation. He is given the possibility of reacquiring the real exercise of rights and, through strategies based on social contractuality, is empowered and enabled to construct a multiplicity of identities.

The closing of the psychiatric hospital is an indispensable step in de-institutionalisation.

The work of deinstitutionalisation in Trieste

Since 1980, Trieste is a city without a psychiatric hospital.

What follows is a summary of the steps which brought about the closing of the psychiatric hospital in Trieste and the construction of a network of community mental health services.

Freedom is therapeutic

In August, 1971, Franco Basaglia becomes the director of the provincial psychiatric hospital of Trieste.[1] With a group of young doctors not yet contaminated by traditional psychiatry, as well as psychologists, students and volunteers, he begins an intense project for the theoretical-practical criticism of the institution of the asylum. At this time, there are about 1,200 patients in the San Giovanni psychiatric hospital, most of them compulsory.

From 1971 to 1974, the efforts of Franco Basaglia and his equipe are directed at changing the logic and rules which govern the institution, placing the hierarchy in question, changing the relations between operators and patients, inventing new relations, spaces and opportunities, and restoring freedom and rights to the inmates.

In the hospital in transformation, guardianship is replaced by care, institutional abandonment by the full assumption of responsibility for the patient and his condition, while the negation of the individual through the concept of illness-danger is substituted by the conferring of value and importance to individual life histories.

Shock therapy and any form of physical containment is suppressed, the mesh and barriers which enclose the wards are removed, gates and doors are opened, compulsory committals become voluntary and definitive ones are revoked, thereby restoring civil and political rights to patients.

Work is carried out on two fronts: on the one hand, its efforts are directed at reconstructing the long-term inmate as a person and an individual with rights and, on the other, at interrupting the spiral of chronicity for new arrivals through releases which are as rapid as possible and a crisis intervention which seeks to avoid alienating the individual from his family, work and social environments.

A new administrative figure - the “guest” – is created for those who have been released from the hospital but are still unable to find the conditions for an autonomous life within the city and/or still require protection, even if only housing, before returning to their social environment.

Changing and improving the inmate living areas (with non-institutional furnishings, personalised decorations, etc.) and the communal areas (lounges, bar, social areas…) becomes a priority; partitions, paint and personalisation are the order of the day. Everyday objects such as mirrors, cutlery, shoelaces and combs once again become commonplace and institutional apparel is exchanged for regular clothing.

The employment histories of the guests are reconstructed in order to obtain labour pensions, procedures are initiated for social or invalidity pensions, and the use of economic subsidies for released patients is widened and improved in order to “prevent new hospitalisations or the worsening of illness” (Resolution of the Provincial Administration, 1972).

Events and encounters between patients are promoted in order to overcome the segregation between men and women, and parties, concerts and performances by well-known artists are organised on the hospital grounds in order to encourage the general public’s entry into the hospital and break down the wall of separation.

Periodic patient assemblies are begun, as well as daily ward staff meetings and general meetings of the entire equipe with Franco Basaglia.

Patient outings within the city are encouraged, while the local population begins to discuss, often in a critical manner, the idea of an “open” hospital. Relations with the patients’ families are resumed, and home visits for those who have been released are initiated in order to provide support and prevent new hospitalisations.

The first residential groups are organised (in the former residences of the director, general administrator, chief psychiatrist, as well as in town) for long-term patients

[1] In 1971, the province of Trieste has a population of 310,000 in an area of 212 sq. km. The city has a limited hinterland which s almost completely surrounded by the border with the Republic of Slovenia. Since 1971 it has been in continuous demographic decline: in 1998 the population was 252,000, 24% of which over 65 years of age.

who have been released from the hospital. They are staffed by operators and nurses who are also thus "freed" from the hospital wards.
The criticism of work-therapy, a practice which objectifies, is repetitive and for the most part merely a substitute for the work done by regular employees, results, in December, 1972, in the creation of a labour co-operative for around 60 persons. The patients, who are now members of the co-operative, continue to work cleaning the wards, working in the kitchen, the laundry, in the transport services … with a regular union contract, and no longer in the name of a therapy which "kept them busy" as inmates without any rights.

Overall, the process of institutional transformation is complex and difficult, and takes place amid numerous difficulties. Internally, there are problems especially with the nurses and their unions, who do not feel protected in the workplace and have great difficulty abandoning the traditional role of "guardians" in order to assume/express therapeutic abilities. Externally, there are conflicts with the bodies for the protection of the patients and with the Public Prosecutor's Office regarding the release of patients, the transformation of compulsory hospitalisations and the revocation of permanent committals. There are also conflicts with the local population which is forced for the first time to deal with the suffering, misery, diversity and deviance formerly hidden by and within the psychiatric hospital.
But a process - and a confrontation - has been initiated in Trieste which can no longer be ignored or interrupted.

From the hospital to the community

From 1975 to 1980, while the work of transformation and releasing patients continues within the hospital, the operators begin to manifest the need to "go beyond the walls" and "accompany" the long term patient in the community in order to support him in his daily needs, encourage his access to the city, the family and social network, and the institutions, and respond to the suffering/illness of persons within the community, where this suffering forms and expresses itself.
From 1975 to 1977, the operators select and start up 7 "outposts" in the province of Trieste, the Mental Health Centres. These are located in different areas of the city and have a catchment area of about 40,000 people each. As outposts in the community which have been created to meet the needs of the patients released from the hospital, they represent places which are alternative to the hospital for "shouldering the burden" and providing care for *all* persons with mental health problems.
In January, 1977, Franco Basaglia holds a press conference to announce the project for closing the psychiatric hospital. Even though 32 patients and 433 guests still remain in the hospital and the ward for the reception and hospitalisation of acute cases is still functional at the time of the announcement, the deconstruction of the hospital is by now consolidated. There is thus the need to ratify a process which can no longer be reversed.
In February of the same year, a 24hr on-call service with one doctor and two nurses is activated in the emergency room of the general hospital. Its purpose is to reduce compulsory hospitalisations, improve crisis and emergency interventions and, by bypassing the psychiatric hospital, refer an increasing number of users directly to the Mental Health Centres.
In May, 1978, the psychiatric reform bill, Law 180, which incorporates the operational guidelines already being implemented in Trieste, goes into effect.
In November, 1979, Franco Rotelli takes over the direction of the services in Trieste.

The 24hr Mental Health Services

In March, 1980, the Mental Health Centres (MHC) begin to function full-time – 24 hrs a day, 7 days a week. Each Centre is equipped with 8 beds in order to provide day-night hospitality and care for the patients and residents of their respective communities. They function in conjunction with the Psychiatric Diagnostic and Treatment Unit in the general hospital, which is provided for by Law 180 but structured in Trieste as an emergency service with 8 beds for temporary or overnight hospitality and as a consultancy service for the hospital.
In April, 1980, a resolution of the Provincial Administration formally recognises and ratifies the cessation of the functions of the psychiatric hospital and simultaneously ratifies the organisation of the new community services (the MHC's), the Psychiatric Diagnosis and Treatment Unit in the general hospital and the service for the long-term elderly patients within the former psychiatric hospital. At this time, there are fewer than 400 guests in the ex-hospital, where work continues for their rehabilitation and release.
In the Mental Health Centres, the equipe, doctors, psychologists, social workers and nurses, in collaboration with other community services, .carry out an intense work of home and out-patient care for persons with mental health problems and their families. Each MHC has a canteen for hospitalised and day-hospital patients, a service for social assistance and a pharmacy. The MHC's also constitute a place for meeting and socialising, and for the promotion of rehabilitative activities and social integration.
The MHC's are open during the day from 8am to 8pm, and anyone can have access without any bureaucratic procedures or requirements. At night, the centres provide hospitality for overnight guests and are staffed by 2 nurses.
Persons requiring psychiatric assistance during the night are referred to the Psychiatric Service in the general hospital. The following day, their case is referred, if necessary, to their local MHC.

The network of community services

From 1980 to the present day, the work of the equipe in Trieste has pursued the following goals: widening and improving the response to the health needs of the local population; strengthening the networking with all services, both public and private, that exist in the community; improving the services and projects offered; multiplying encounters with local institutions and creating networks of solidarity.
With the help of artists, art teachers and professionals, expressive, rehabilitative and training workshops have also been established and a growing attention to job training and placement has also been developed with the creation of new social coops for service users and young people within the city.
The rehabilitation and release of guests from San Giovanni, the ex-psychiatric hospital, has continued utilising autonomous living quarters and group residences and the original grounds have been improved and returned to the city for other uses.

1998 – The Trieste Mental Health Department

Today, the network of services, which are integrated into the Mental Health Department (MHD), are as follows:

- 4 *24hr Mental Health Centres*, each serving around 60,000 people. Each MHC is provided with a staff of, on average, 4 doctors, 1 psychologist, 20 nurses, 2 social workers, and has 8 beds for day-overnight hospitality. One operational unit is dedicated to the *Women's Mental Health Centre* which deals with specific issues connected to women's health since 1992, and experiments with diverse therapeutic and emancipatory itineraries.
  Each Centre carries out an activity of prevention, care and rehabilitation, articulating its intervention in the community through out-patient and home care,

social support, job placement, family support, housing assistance and networking.

- The *Psychiatric Diagnostic and Treatment Unit*, with mostly consultancy functions for the general hospitals emergency services and its other wards. It has 8 beds for overnight care and the hospitalisation of patients who also need other forms of medical assistance.

- The *Rehabilitation and Residence Service* co-ordinates the structures which are specifically designated for activities of training, rehabilitation and social integration. In particular, it manages and co-ordinates the Department's residential structures, the activities and workshops of the Day Centre and the relations between the Department and the social coops.
  The MHS has 29 residential structures. These host around 140 guests which are ex-long term patients and users of the MHC's that need support in their daily activities and/or an individualised therapeutic-rehabilitative process.
  The Day Centre's crafts, expressive, training and empowerment workshops are complex areas for culture, socialising, education, training and empowerment. Here, through small, group activities, individuals acquire abilities, qualifications, relational abilities and construct pieces of health and contractuality.
  There are 4 social coops[2] which work in close contact with the Department and in different areas of activity. They have more than 200 working members, more than 50% of which come from categories at risk, or are MHC users in job training. The job training and job placement activities are an essential part of the empowerment process. Currently, there are 110 users in job training with the social coops or private businesses within the city. From January to October 1997, 29 users in job training have been taken on as regular employees.

  Since the early '80's, a service made up of MHC operators has been working in the local prison. The aim here is to guarantee a therapeutic continuity for the user inmates, respond to new demands made by citizens-prisoners, avoid/abolish referrals to forensic hospitals and encourage measures which are alternative to prison.

  In collaboration with the Mental Health Department, there are 3 *volunteer, family* and *self-help associations* which work in the specific area of the fight against processes of social exclusion and for the affirmation of the full rights of citizenship for persons with mental suffering.

Some considerations on the work of deinstitutionalisation

In Trieste, the process of deinstitutionalisation has restored full rights to the mentally ill person, given him access to social citizenship, and multiplied possibilities and

[2] The "F. Basaglia" United Workers Coop: created by the deinstitutionalisation of the psychiatric hospital in 1972, today it is an important economic and entrepreneurial organisation. It has 162 worker-members of which 53% come from disadvantaged sectors. Its activities are: cleaning, laundry, canteen, porterage and book-binding.
"Monte San Pantaleone" Agricultural Cooperative: established in 1979, it works in the gardening sector for both private clients and the public administration. There are 10 worker-members 10, of which 70% are disadvantaged.
"Wild Strawberries" Cooperative: established in 1979, it operates in the public service sector; it manages a hotel, a hairdressers and beautician, and a bar-restaurant. There are 16 worker-members of which 56% are from disadvantaged sectors.
"The Hill" Cooperative: established in 1988, it operates in the communications and multi-media sectors. It manages a community radio station, an optical archiving and public relations service for the city of Trieste. There are 17 worker-members, of which 58% disadvantaged.

opportunities for him, the operators and, in the final analysis, for the entire community.
In the context of public health, it has also brought about the transition from a circuit for control and custody – the psychiatric hospital – to a circuit for shouldering the burden of suffering and illness and producing health in the community.
The violent and coercive practices of the psychiatric hospital have been replaced with practices based on consent, sharing and co-existence, all elements basic to mental health. Distance, non-involvement and the absence of inter-subjective relations have been replaced with closeness and complicity.
The object of mental health operators is no longer illness, but the individual who experiences and expresses a situation of suffering within his social context. Social danger is no longer automatically tied to illness; instead, it is the social environment and the absence of responses by the services which are seen as constituting a threat to mental well-being. Chronicity is no longer an unavoidable attribute of the patient with a mental illness, but an historical artefact to be identified with the operating methods of services and the symbolic order of internment.
In mental health practice, value is increasingly given to diversity, the promotion of connections and exchanges and social coop strategies.

At this point, it might be useful to recall certain dates and indicators.
In Trieste, from 1971 to 1997 the population has decreased from 310,000 to 252,000, while the number of persons with problems of mental suffering has gone from 1160 inmates in the psychiatric hospital in 1971 to 3005 users of the Mental Health Centres in 1997.
The health budget for psychiatric assistance has gone from 5 billion lire (54 billion lire at current values) to 25 billion lire. The number of personnel has gone from 524 to 271 units.
The 1160 beds of the psychiatric hospital in 1971 have become 32 beds for day-overnight hospitality in the community services in 1998, plus the 8 beds in the Psychiatric Diagnostic and Treatment Unit. There are 140 places in the residences, which have different forms of assistance, and which offer different housing and therapeutic-rehabilitative opportunities.
The number of compulsory hospitalisations in 1971 was 150. In 1997 it was 27.
There were 20 persons interned in forensic hospitals in 1971, today the total is 0.
The number of suicides, around 20 per 100,000 inhabitants (which is extremely high with respect to the national average) has remained virtually constant in the last 27 years.
The buildings and grounds of the psychiatric hospital have been returned to the city. They now host places for research, study, training, work and socialising. Today, more than 2000 persons daily live and work in the old hospital grounds, which as become a sort of laboratory for coexisting in diversity.

In Italy, albeit more than 20 years after the passing of Law 180, we are putting a definitive end to the psychiatric hospital, even though this change is being implemented more though the annual national Budget Plans than through the commitment of mental health operators.
The psychiatric hospital is disappearing as a physical and symbolic location, as a place for the production of illness, even if the “internment paradigm” continues to provide the basis for the practice of many psychiatrists.
The current issues which we must continue to concern ourselves with and for which we must remain vigilant are: the relation between the definitive superseding of the psychiatric hospital and the construction of a network of “strong” community services, the various rationales which must support these services in order to respond to the health needs of the general public, without re-proposing the construction of a “new chronicity” and the places for its containment and, finally, the issue of the responsibility operators have towards patients with mental illness.

New tasks await us. We must commit ourselves to closing private psychiatric hospitals, abolishing publicly subsidised clinics – the new asylums which public psychiatrists have created and finance – and finally, shutting down forensic hospitals.