Globalisation and the challenge for mental health services.

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Some reflections on globalisation and mental health

My contribution today takes its departure from a number of recent international events, in particular the no-global movement and the terrorist attacks in America, which have made all of us more aware of the general context in which the new network finds itself immediately and dramatically situated. I believe that these events underline the need for a more profound analysis of the meaning of 'globalisation' in terms of mental health and that globalisation represents a challenge for our network, and not only in terms of a resistance to it.

As is known, in many parts of the world globalisation, especially when combined with an increase in population, has resulted in an overall increase in the level of poverty; and where it has generated some form of development, it has resulted in an increase in social and economic inequality and a general deterioration in health, education and living conditions as a consequence of the processes of economic restructuring.
Some of the powerful forces which affect social – and thus mental – health are poverty and malnutrition (according to Nancy Sheper-Hughes the so-called 'nervios' of the *favelas* in Brazil are related to the sensation of chronic hunger), urbanisation without economic development, micro- and macro-social violence, emigration and catastrophes.
The recognised increase in neuro-psychiatric disorders is linked to both the absolute increase in the risk population (e.g., schizophrenia and dementia) as well as other forms of social and psychological morbidity related to social behaviours such as alcoholism, substance dependency, suicide and para-suicide, violence against women (which varies from 20 to 75% of the female population), abuse and abandonment of children, forced prostitution, street violence and criminality, state violence, ethnic conflicts, and the uprooting and forced emigration/displacement of large numbers of persons.

However, if poverty is one of the prime indicators of mental illness, economic prosperity on its own does not necessarily guarantee personal and social well-being. The globalisation of these issues is not just limited to developing countries, where a distorted model of development and/or exploitation destroys original economic and cultural resources with disastrous effects on mental health. It is a certain type of globalisation which is at issue, and development (or the lack of it) cannot be simplistically linked to this increase in morbidity. In developed countries as well, poverty and social injustice exacerbate existing problems and confirm the paramount importance of processes of exclusion and the nexus poverty-illness which Basaglia denounced repeatedly in his writings – a nexus which is two-way and circular. Forms of development which create new inequalities and violate human rights will only exacerbate the individual and social suffering which is linked to material living conditions.

An emerging problem is the persistence of forms of second-class citizenship (Rowe) and thus of the lack of social inclusion for immigrants in western countries. Their access to care often remains problematical due to approach, cultural diffidence, a marginal position with respect to the institutions and the rights and responsibilities welfare systems – to arrive ultimately at the homeless, or the total lack of a relationship with the state.

Mentally ill people around the world suffer from some level of exclusion and deprivation of rights (from extreme cases of the total deprivation of legal and civil rights – to the lack of social rights) and have taken their place alongside other excluded social groups.

In this context, we should recall that the World Development Record of the World Bank (1993) entitled *Investing in Health*, has already recognised that health indicators have the same value as economic indicators as markers for the effectiveness of development policies. Investing in health thus remains crucial for development.

In poor countries, psychiatry is only a small part of the much larger, general issue of mental health (and of health *tout court* – for we now know, thanks to the development of primary care systems, just how strong the nexus between health and mental health really is). In these countries, psychiatry, which was often inherited from systems of colonial domination or, in any case, has imported European models of asylum-based exclusion, is incapable of governing the social contradictions between normality and deviancy (as it seeks to do in western countries). In fact, it does not even attempt to do so, with the exception of isolated asylums.

Mental health reveals everywhere the connection with **social determinants**, and much more clearly at the international level than in developing countries alone, where the private dimension and the emphasis (at least in formal terms) on personal rights tends to confine ill-being to the individual level, thereby making it more difficult to discern its transversal, social nature.

However, as always, psychiatry plays a role in organising social consensus (Basaglia), for while in poor countries it still tries to reproduce the old custodial institutions, in wealthy countries a ‘new and improved’ psychiatry attempts to re-propose under different guises custodial models based on danger; and while it stresses the individual dimension, it at the same time disengages itself significantly from social issues and limits its interventions only to those aspects which represent ‘risk’ (risk assessment, security beds).

The striking outcomes contained in the WHO studies on schizophrenia in ‘developing countries, have shown the extent to which extra-clinical factors or variables (of which psychiatric assistance levels are of secondary importance, given the small minorities

worldwide which have access to care) predominate over etiological ones, in terms of their connection with 'mental illness'.
In areas where strong social *noxae* are present, their impact can be defined as 'semi-causal' or, in any case, go well beyond being simply risk factors. Mental health and the quality of life are intimately interconnected, as are mental health and social/cultural development / living levels / survival.
The problems listed above typically occur in clusters. The same risk factors responsible for the onset of disorders are also associated with their chronicisation; they interact according to multi-factorial models which likewise induce negative 'spirals'.

The link between economic development and health once again raises the issue of the need to develop society's human potential, and thus the connection between social and health policies, given that the former have direct and visible effects on health indicators. For example, the link between the educational level of women and the reduction of infant mortality, family violence and alcohol abuse is well known.
Amartya Sen (1990) has calculated that in Southeast Asia, 100 million women are 'missing' due to premature death by selective abortion, female infanticide, discrimination in medical care and conditions of exploitation.
What has been called the 'worldwide epidemic of domestic violence' leads one to social policy interventions as well as specific community programmes which encourage the empowerment of women. However, there is also a call here for 'advanced' countries to develop similar integrated strategies.

Issues of the medical model

Due to its contradictions, globalisation presents us with a struggle at two levels in which the 'adversary' is the overwhelming economic and cultural power of the pharmaceutical industry. There is something almost paradoxical in the need to obtain a social price for psychiatric medications which are essential for guaranteeing care in poor countries, while at the same time criticising the absolute therapeutic value conferred upon them by a bio-medical model which once again tends to conceal the social factors linked to mental disorder, thus undercutting the possibilities for effective psychosocial and community treatment.
This cultural influence is evident in another emerging contradiction, or the movement towards ever more uniform diagnostic systems (ICD, DSM). This trend, which is driven by the need for the rationalisation and comparability of therapeutic systems and their effectiveness and viability, is criticised not only by the trans-cultural and anthropological approaches (Littlewood), but contradicts the need to endow personal crisis and distress with a social meaning so that support networks for providing care can be motivated and made more sensitive. The IPSS study (WHO) confirmed the substantial ubiquity of schizophrenia, and thus of its "existence as an entity". However, the research was based on a tautological methodology which 'found' an **object pre-identified by the codes of recognition utilised** (PSE), and therefore identified and registered a specific symptomatology and not the total demand (Mezzina, et al).

Certainly, subjectivity is determined by the existing social modes of reproduction. But in terms of what interests us, ie. the user's experience, the **forms which impact on individual subjectivities** in crisis are everywhere the same: the medical model and medical-psychiatric knowledge/power. The crisis of this power has resulted in a differentiation of technical tools, which in turn has led to the appearance of new objects

(such as the distinction between patients and out-patients, a distinction which exists only in the rationale of the psychiatric apparatus; or the multiplication of technical practices and figures in occupational therapy and so-called rehabilitation, understood as a preconceived *technological* response to needs). The 'bottom line' of this knowledge/power, its social *raison d'etre*, is exclusion; an exclusion which was once guaranteed entirely by forms of internment or abandonment and which still continues to condition the relative impotence of the patient in new ways.
Today, the break-up of this totality (though with the power gap remaining intact) has resulted in an intermittent cyclicity, alternating between hospitalisation and discharge/abandonment, typical of a medicalised psychiatry.
This presumed change or, better, adjustment of the medical model, re-establishes the distance from the patient because it refuses to deal with, or recognise the object of its intervention (the patient) in its entirety. Selection, and the 'new psychiatry's' fragmentation and hierarchical structuring of roles fragment the object (the patient); the technicalisation of the approach, continually renewed, chooses and discards, creating residuals.
Thus, if we consider relationship between subjectivity and psychiatric apparatuses, we must ask ourselves what sort of subjectivity the mental health intervention expresses, and take our departure from there. The only subjectivity allowed within the new circuits is that sanctioned by the medical model, in the codes of acuteness and anomy, of abandonment. But this subjectivity is fragmented because selected in its moments of expression in accordance with the modules, the containers of the apparatus, and so to for each individual subject with respect to any other.
What strategy is possible that does not involve an imposition of power? That of always making the needs of the whole person grow and emerge, permitting and making possible that this person is 'whole' within the social space.

Transformational knowledge

Psychiatric knowledge has always been constituted and then modified based on a dialectic with the existing institutional set-up, in a process which confirms and legitimises that set-up, conceals and supersedes it, or prefigures the assumption of new tasks. Hence, no intelligibility of behaviours, no knowledge which adheres closely to its object is possible without a knowledge of and about institutions and the related therapeutic practices. This interaction has never prevented such practices from crystallising into forms which are at any given moment fixed and reified and, even though susceptible to partial change, are always implemented in the immutable setting of the asylum, which provides the ultimate rationale and cultural background for their meaning and their use as tools of the apparatus.
The negation of an *à priori* scientific status for psychiatry, its existence as an area of social un-reason in order to control and integrate that un-reason with respect to historically determined norms, should prompt us to once again consider the problem of psychiatric techniques, knowledge and know-how in terms of their being connected to a context and a purpose, and to a dialectic among various forms of power.
The 'object' of this 'new' knowledge thus cannot be limited to the 'suffering' person, or their social behaviour or personal experience, even if understood in neo-ontological terms which confers dignity upon the individual by recognising the uniqueness of these elements. A critical knowledge must have as its object the uses and aims of the knowledge itself, and the **context in which this knowledge is applied**. If the individual is not seen as embodying the contradictions inherent in the historical and social context

(contradictions which an 'uninterrupted relationship of meaning' (Doerner) cannot reconcile if the social context remains unchanged) a new distance would be sanctioned with respect to the person who suffers and their experience.

In a globalised perspective, the "economy of knowledge" (Giddens) must be recognised as one of the most powerful forces in action.
There are two views on how transformation can be achieved: on the one hand, the need for a cultural frame of reference within which the awareness of the meaning of that transformation and the direction of the practice of change can take shape in a personalised vision of activating subjects (which raises the issue of how **the knowledge for transformation** can be transmitted by those who possess such knowledge) and, on the other, the view that only a change in the legal context – laws, alternative structures, etc. – can create the conditions necessary for transformation to take place.
However, the essential thing is that the **Institutional Mechanism** be attacked and changed at various levels. In terms of the circuit, this means the refusal of separation, selection and the 'adding on' of services; it means the analysis of the single, subjective situation in relation to the circuit and the possibility of impacting on the comprehensive or overall itinerary of the demand ('shouldering the burden'). With respect to the internal functioning (operational) model of each individual institution (service), it means transforming the work organisation, and stimulating and drawing forth subjectivity and needs on both sides of the therapeutic relationship (operators and users).
The issue of know-how and knowledge must thus be redirected back to *subjects* (individuals) and *places*, in order to make it possible for the 'otherness' of such knowledge to appear, and not in the abstract, but as an integral part of the transformation of the latter . The problem of technical operators as both institutional 'subjects' and institutional 'managers' is linked to the issue of institutions as 'objects' and their conditioning of the operators' actions, thoughts and production of knowledge.

Against institutions of exclusion

This Network's founding document contains important specifications of a theoretical and theoretical-practical nature which give content and substance to what might otherwise seem to be only a list of aims and criteria.
In particular, I would like to draw attention to the strong choice which has been made *against psychiatric hospitals* (and for the first time with the support of the WHO Department of Mental Health and Substance Dependency thanks to the efforts of Benedetto Saraceno) meaning the closing down of psychiatric hospitals and the fight against all forms of coercion, containment, physical violation, confinement and incarceration in mental health; and thus against all practices of dehumanisation and exclusion (psychiatric exclusion as a facet of social exclusion). The right to care must be linked to the rights of citizenship, the former cannot be given in exchange for the latter.
The asylum model entered into crisis because it was no longer possible to justify such institutions and because of the growth and differentiation of the psychiatric demand and the social area which psychiatry was expected to respond to (social control). However, regardless of where an operator finds him/herself, or where they are situated on the overall institutional map, asking where , asking where they are 'here and now', means dealing with:

a) the inequality of psychiatric care with respect to social or economic class, and the contradiction public-private;
b) the reality of the chronicisation of the circuit, the reality of abandonment and the persistence of places for, and practices of internment;
c) the contradiction between the problem of *management* and the problem of the person as *subject*;
d) the (physical) relationship with the individual's living conditions (and thus their social reproduction), and 'shouldering the burden' of the comprehensive or overall demand for care.

Community services

The network's document speaks of the *community service* as the central, unified and integrated strategic-organisational moment which must direct its vision towards the *centrality of the user's needs*, with the 'user' understood as an active subject in an itinerary of healing, recovery, social restitution and emancipation. The criteria for the creation of such (desirable) services are based on the idea of a new organisation of the community which goes beyond the concept of new institutions and the risks of a new institutionalism. Instead, it envisions *horizontal organisations* which are internally open and participatory, made up of people, of men and women who work as professional subjects immersed in a community to which they must respond and be accountable, such that the organisations themselves must also respond to the community. They must be accessible to needs and demands and must offer flexible services based on the non-selection of users, the integration of resources and maintaining and dealing with the most difficult cases *within* the community.
A **single model** is not possible because it would remain an abstraction. The purpose of the model is to provide a service which controls the circuit and unifies the response, and does not produce 'screenings'. The service *must* differentiate itself continually from within, by a sort of negative entropy, through a process of ongoing change with respect to the demand. It should have a constant relationship with this demand, for only if it is accessible is it possible for the needs themselves to be expressed. When a service organises itself for the purpose of responding to needs, this can change the relationship between the general public and institutions. All these elements condition the political essence of our work, which is the overall function of the institution with respect to the social system.

Community networks

The forces which contribute to personal well-being and possibility are as much local as they are national and international. Collectivities and social networks are situated between regional policies and economics and everyday life, and offer protection for some while placing others at risk. Class, ethnic origin, gender and age are especially powerful mediators which deflect or intensify the consequences of broader social forces. The forces – social ties and their cogency – which hold the community together are counterpoised by the value attributed to the individual based on **power and class** structure. And while a network may attenuate social and personal crises, and eventually protect vulnerable individuals, it cannot mobilise resources which do not exist (Desjarlais etal., 1995).

The problem of the relationship with the community passes primarily through the **building or strengthening of networks**. Our document underlines the importance of networks and refers to the need for '*creating community*', understood as the centre of operational activities, or the ability for a service to produce networks and interact with existing networks. From the primary networks, or those networks existing in the social fabric, through the activity of the network; to *networking* with the services in the community, especially social services, community health services, the 'primary care' system, which must be contaminated with respect to the theme of health, and comprehensive health projects, within which mental health is also situated. Finally, the building of new networks, the invention of all the possible ways of interaction with individuals, social groups and forms of aggregation, co-operation and association. All of which is distinct from the emphasis placed on informal as opposed to (or in opposition to) formal services.

Formal and informal services

We do not believe that the problems of developing, as well as western countries should be solved by the simple dissolution or demolition of what constitutes the right to health care, which these countries must guarantee through a sustainable system of public assistance. The problem which arises here is twofold: the enormous difficulty of access to care by people in developing countries and the issue of rights.
We believe that this is not only cost effective, but also compatible with psychiatric and mental health practices based on **the recognition of the limits of systems of assistance**, especially if authoritarian and asylum-based and imposed on a given population from above, and which enhance and give value to the resources of individuals.
In addition, public mental health services are sometimes seen as an 'optional' for the public health budgets of poor countries who must provide essential health services, in that there is the tendency to consider that the 'informal' systems or services, which are represented by the support practices of the community itself or by forms of traditional medicine, are in themselves sufficient if not preferable because homogenous with the culture in which they function. However, experience shows that these can be just as, and at times even more oppressive than the most institutional forms of care of colonial derivation (the practice of tying derelicts, the abandoned and the most serious cases to trees in Africa, for example). While respecting the local communities, allowing themselves to be controlled by them and mobilising the resources within such communities (for example, through the identification, as was done in the '80's in, in the region of Cordoba, in Argentina, of 'informal community mental health agents'), interventions must not only place the emphasis on maintaining human rights but provide a surplus of resources and transformational knowledge and know-how. The best programmes will establish a proper dialectic between the liquidation of residual forms of institutional care inherited from colonialism (the deinstitutionalization of structures and knowledge) and the strengthening of local forms of assistance, even if experience shows that such integration is not always possible and critical tensions may occur.
We should like to recall here the 5 criteria proposed by Desjarlais, Eisenberg, Good and Kleinmann for a map of a local system of psychiatric assistance:

- if it meets the fundamental mental health and behavioural needs;
- how it is decentralised;
- how it is integrated;
- how subdivided in different sectors and services;
- if it provides continuity of care.

24 hr community services means providing **wider, more democrat access**, as against services which discriminate by social class (privatised) and are profit-based. In the context of operating through networks, the private-social (NGO's) enters into this contradiction, and make decisive changes by offering more democratic development models in mental health, and this as a specific alternative to the residues of a psychiatry dedicated to the social control of deviancy.

Towards an integrated service

Fortunately, after the uniformity of the asylum, the relativity of 'local' mental health systems has affirmed itself, a relativity which is based on therapeutic tactics, not strategies.
Once we have moved beyond the notion of all-inclusive services which pretend to respond to the needs of the whole population (Wing), a principle which is inapplicable on an international scale where resources are extremely limited, it is necessary to enhance and develop the relations among social networks and local, community services which succeed in providing a comprehensive approach to mental health. If we consider the fact that one operates in an open system, then it is not really true that psychiatry always operates with limited resources. The promotion of mental health is the reconversion and invention of resources, and not just the effort to optimise services.
How then, does this partnership work? While retaining faith in the ability of social networks to mobilise themselves and maintain cohesion, crisis theory reminds us that it is the rupture in the equilibrium of social micro-systems and their inability to deal with this break which makes an external intervention necessary. But what kind of intervention? In defining the mission of public mental health services against internment – as an alternative to internment – what social models are available? Most certainly it should be a model which is participatory, in order to oppose non-access (or the refusal of access) and the *de facto* abandonment of patients. It should be a model which is based on a new equity.

In my view, mental health should not offer easy solutions (it has been said that we should avoid applying the **"rationalistic paradigm"** *problem-solution* to therapeutics, for all 'non-solutions' would inevitably be 'collected' by the asylum in order to maintain the 'order' of such a paradigm"). However, I fear the Italian (mainly Triestine) concept of deinstitutionalization, which began with the de-construction of the institutions and psychiatry in order to arrive at de-construction of the Illness, has been and still is largely under-valued and misinterpreted [1].

[1] Strategies of deinstitutionalization, according to De Leonardis, Mauri and Rotelli (1986), are outlined as follows:
- 1) MOBILIZATION of all social / institutional actors involved (workers, patients, families, administators, laymen)
- 2) RE-ADJUSTING POWER BALANCE between institutions and patients
3) USING INNER ENERGIES of the institution to dimantle
4) LIBERATION FROM THE SOCIAL NECESSITY OF SECLUSION THROUGH TOTALLY ALTERNATIVE COMMUNITY SERVICES, "responsible" for a certain population in terms of mental health
- 5) RE-CONVERSION of public resources (staff, financement) = directly used by patients (for their welfare)
- and productivity of these resources
- 6) RE-ORIENTATION of staff for new (more complex) skills.

The new solutions for community care cannot limit themselves to being efficient only in terms of the "object-illness" (as with "functional team" approach), but must seek to preserve the idea of the person as a whole, even to the point of considering mental illness a part of that whole. The service must thus seek to envisage this "whole". Its vision must not be technical but human. It must constitute a place where different subjectivities can encounter one another.
In practical terms, it does not exclude functional approaches (ACT, crisis teams etc.) but much depends on the context in which these strategies are applied. For example, I fear that a "technical use" of this sort on a large scale, as in the UK National Service Framework, is incapable of changing the face of the mental health services in a real or significant way, and tends to reproduce institutions in the community.
However, neither of these hypotheses takes into account **the risk of modernisation** present in the adjustment of the psychiatric circuit or professional corporations. It is clear by now that transformation cannot occur through the successive modifications and differentiations of existing structures (institutional engineering), which only reproduce unaltered the same approach or perspective of objectified suffering.
Thus, how is it possible to attack the psychiatric rationalisation of Welfare which has created **'screens' of services around the asylum**, and a fragmented and isolated array of knowledge and professional figures. Where does one begin? The asylum exerted an enormous power for the centralisation of knowledge and practises, and for making them conform to its own schema. But now that it is only an archaic 'leftover' (however fundamental for understanding the overall situation), it has been allowed to fade into the background, creating a false freedom and anomy for the new specialisations, almost as if they were capable of self-determination. But the apparatuses define such specialisations before the fact by situating the specialist within a narrow band of competencies. All **efficiency-based models**, founded on a differentiation of techniques, provide for the exclusion of 'residuals' – residual in the sense of being subjects, or of being pieces of subjectivity; residual in the sense of being the material conditions of subjectivity. These residuals will either never arrive ('come through the door') or will be actively excluded (through selection of the demand, or of the field of intervention) – or will do so only at the cost of causing a crisis in the technique itself.

In my view, **an integrated service** means that we must question ourselves at length concerning the following issues:

- Itineraries of the demand (accessibility: whether with a single or multiple points of entry, but with maximum flexibility for the demands that enter);
- Coherent response (connections between programmes and structures, working out failures)
- Internal coherence of the system (a network) (system of relations, quality of the human environments)
- Subjects / subjectivity (plurality) and power (representation of requests and needs):
  professionals (at different levels)
  users / family / community
- Position in the social-health services: separation / exclusion for user; auto-referential; difficulty in accessing other resources).

Services must be re-designed in terms of:

- structures (settings): hours; adequacy of locations, facilities; physical accessibility
- functions: specific and/or transversal with respect to the structures; integrated

- programmes (prevention / care / rehabilitation): transversal integration in a given community (department concept)

The training and reskilling of personnel must be based on the development of a service culture: creating the communications medium with respect to goals and the mission / system of values. Weick's three levels – values / procedures / (im)mediate interactions and practices among the actors – they must be bound by a strategic coherence.

A transformed knowledge?

Mechanism, role, technical-political subjectivity, laws and legal framework, institutional engineering, circuit: the task could be to reformulate their relationship with transformational knowledge and know-how.
What possible strategies exist that do not involve the imposition of power and which enable the needs of **the whole person** to emerge and grow, making it possible for them to be a whole person in society?
Everything that can be said about individuals, subjects, and the response to their needs and personal histories should be considered in the light of the fundamental contradiction between *management* and the *subject*. At issue here is the professional role, how much it produces in terms of repression, and how much it can give in terms of liberation. Between the operator and the user there is the institution and its function of reifying subjectivity, eroding its power and identity, and substituting and conceding identities which are false and in conformity with its role as a social container.
Transformed knowledge, and knowledge which continues to transform itself, is knowledge which is contained in the practices for 'shouldering the burden', and for sustaining and actively aiding, step by step, the social itinerary of the person who suffers by transforming this person's relationship with the Institutions (overturning *management*). These are the conditions which constitute the framework for the technical act and direct its meaning: when the operator explicates his/her role and places it in question, it is possible to initiate a relationship among powers, a contractuality for users.
We cannot define in concrete terms the subjectivity that is produced in a relationship which breaks the rules by permitting both **the operator and the user** to express themselves, thereby enabling a third actor - the community - to enter. We do know, however, that aside from any presumed emancipatory content that is transmitted or the specific form of that content, this relationship breaks down the rigid forms of social control.
The **response to needs**, to the material reality of life and the subjectivity that traverses and permeates it, cannot be an operation of decodification of everything that lies 'behind the medical question', but must be the creation of a space for listening and for the subject's expression which permits that individual to **present his/herself as a problem**, and to elaborate their unique needs. The process of restoring the user their 'history' can only be the service's history modified *together with* that of the user. It is the common history of our lives together. **'Shouldering the burden'** can only be our awareness, our recognition - we operators, technicians - of a complexity, and how we relate to this **complexity**, how we can create the conditions so that this complexity can manifest itself.
Alternative experiences in psychiatry thus define knowledge and know-how essentially as applied knowledge, as the syntheses of experience and knowledge and the conceptualisation of practice. In the course of institutional transformation, the 'science

of psychiatry' in its crystallised form is effectively broken down; knowledge traverses all of the figures involved in the action of transformation at the moment in which the active subjects multiply, thereby widening the scope of power. The various forms of knowledge thus become tools for transversal communication; they are transmitted, they enter in the cycle of exchange and circulate. Different languages are thereby mediated, and are measured against common sense.
This **new communicative significance** means that there are now three 'poles' involved: operators – users – institutions. In order for a new culture in the enlarged social field to be created, all three of these poles must be impacted upon by both the transformation and the forms of knowledge themselves.
If these political strategies are all at the 'micro' level, this not because transformation is possible only at that level, but because they refer to more general political roles and by starting with the real, concrete situations of subjects, focus their interventions there. In other words, they represent practices of generalisation.

Key-words: the prospect of *recovery*

Today, the major dynamics of subjects and collective subjectivites are emerging from mental health seen as the relationship between individual subjectivities and the existing apparatuses, or the social instruments (dispositivi) delegated for intercepting them, such as the services.
Deinstitutionalization has made it possible to re-establish the rights of citizenship for persons affected with mental disorders not only by permitting them to regain a certain level of power, but also by giving them the possibility of "expressing themselves" and enabling them to speak. It is thus important to understand the connections between alternative practices which are implicitly or explicitly critical of psychiatry and the new forms of self-determination, empowerment and the appearance of users-as-subjects on the social scene, and the link between the possibility of integration and the defence of the value of the experience of suffering as a form of diversity.
The active participation of users in their own treatment, however important in qualitative terms, unfortunately still appears as quantitatively irrelevant when viewed in the larger context, and concerns primarily small minorities which do not impact on the major systems. The involvement of user organisations is symptomatic of a more general tension between professionals and non-professionals, a tension which is present in all practices that are dynamic or in a state of flux and undergoing transformation.
However, instead of these systems maintaining the dominant position, in many countries family members and family organisations are the ones who influence policies, thereby constituting another pole in the dialectic process. From merely representing a social group, vested interests, or a power-block/lobby, these groups have the potential of becoming an important resource for health and transformation. Their importance for care is paramount everywhere and not just in western countries.

Today, the concept of recovery appears as an essential element for combining the experiences which resulted from the deinstitutionalisation of psychiatry and its institutions with the knowledge that emerges from personal experiences through processes of empowerment and emancipation. It presents us with the question of how illness, as crisis, inscribes itself in the personal history of the individual: with what continuity or, conversely, by what ruptures or breaks. When **the subject appears**, when the person becomes visible and illness/psychiatry recedes or diminishes, there likewise appears the possibility of the experience of suffering reacquiring value as a personal

itinerary; as something with interpersonal significance for our social life and the possibility of coexistence. The change represented by recovery becomes possible when there is the discovery of an important meaning with respect to one's crisis/illness, and thus a re-evaluation of suffering. But this can only happen when there is also a recognition by some significant other and/or a mental health service. The service which is able to catalyse such a process is a service which truly produces "processes of recovery".

Qualitative research, based on patient interview, which culls and registers the factors involved and the personal meanings intrinsic to such experiences, appears to highlight the sense of community and participation which the experience of care/healing can open up. It offers the possibility of a new visibility which goes beyond both therapeutic omnipotence and the rhetoric of a passive adjustment or submission to systems of social regulation, for which psychiatry still functions as agent.

Indeed, what relationship exists between healing understood in the medical sense and the **adjustment to intolerable or oppressive conditions**? Recovery means "recognising" oneself and one's problems, as well as the aims of one's existence. It emphatically does not mean "recognising illness" as a sort of 'training' or 'prepping' for the institutionalisation of the ill person. At the same time, recovery cannot be viewed solely as an individual itinerary, for this would, either implicitly or explicitly, sanction the idea of the individual's redemption from a condition - the illness - still considered as a fault or defect.

In re-evaluating recovery as an interpersonal and social fact, we can try to describe three levels:

- Personal recovery, which can be staircased as complete recovery - social recovery - living with symptoms;
- Family recovery: involving the family in a programme of change for persons other than just the "designated patient", which implies the recognition that "his problem is also, in some way, my problem". Often such a process of change results in the development of important social, participatory, community and political awareness (in the broadest possible sense);
- Community recovery: the recognition of the value of participation and the contribution, in terms of integration and not just solidarity, which each member of the community or society can make to the person who is ill, or has been ill in the past.

If we prefer to speak of **recovery *and* "emancipation"**, it is because we wish to underline the lack-of-freedom which is linked to the condition of illness as personal and social misery, the loss of rights, or the denial of access to socially exploitable resources; and, conversely, to the effort which must be made in order to "come back".

In my view, deinstitutionalization, emancipation, social inclusion and citizenship are some of the words that must be linked to recovery in order to endow the process with more meaning and quality.

We must ask ourselves what conception of society and human beings underpins recovery. Otherwise, it merely remains within the medical model of illness (which holds no interest for me whatsoever), as opposed to a "lay knowledge" which is seen as being good in itself, while at the same time being an ideology and reflecting the contradictions of social life. Further, I believe that recovery does not consist in learning some technique as a process of the objectification of experience, and the idea of some gifted 'shaman' or perfect teacher must also be rejected. On the contrary, I prefer to believe in anyone's recovery, and in anyone's personal truth. It is much better when someone is

honest enough to represent and express their personal limits and the contradictions of a personal path.
As with self help or empowerment, recovery runs the risk of becoming merely a catchword, something used to create the illusion of change, and therefore an "ideology" (or worse a religion), while psychiatric services remain locked in their paradigms.
I believe this to be a very tangible risk in Italy, as in all the countries represented here. Nobody explains how good, recovery-based guidelines have the potential of transforming the services, which are institutions dominated in a very material way by their internal logic and their power structures. A good dose of "common sense"? Ethical choices? The only response is deinstitutionalization – perhaps in some new and different form, and based on the recognition of the user's contribution. But even this is not enough.

The search for and production of meaning and recovery processes are the fundamental axes of psychiatric practice, while control (normalisation) and emancipation remain the two poles between which the processes of care and healing move. Where exclusion predominates, the concept of freedom imposes itself in lieu of recovery, just as the concept of full citizenship does not mean very much where freedom is lacking. Thus the need for a transnational and transcultural perspective of recovery, an approach which might also offer some interesting research possibilities concerning the societal reasons for the substantially higher rate of recovery in Asian and African countries despite the total lack of formal services.
What, then, are these 'strategies of emancipation' – of liberation?

New social, political and technical practices

New practices for the promotion of health should be experimented with courage. Some examples of this type of initiative are educating young people to non-violence and interventions in situations of suffering related to war, ethnic conflict, political repression (refugee camps, etc.). The knowledge which arises out of intervention on social networks in many developing countries can prove to be extremely useful in developed countries, where the social dimension is often overlooked or practised only at the micro-level. There is a circularity in the experimentation of new programmes, such that 'community programmes which intervene on street violence in Bogotà can prove to be useful in Boston' (Desjarlais et al., cit.). There is a new awareness of the link which must exist between *culture-sensitive* and *culture-bound* programmes in developed societies and the struggle for universal access to *mainstream services* that are without any discrimination, and with the maximum flexibility. The unresolved **tension between specificity** (ethnic origin, gender, language) **and universality**, between diversity and equality should be (re)proposed as a dialectic node in the services.
If social justice and equality are prerequisites for mental health, then the right to care must be recognised as a fundamental right. This is the aim of the major WHO campaign *Stop Exclusion – Dare to care*, 2001 which, in its declaration of intent, affirms the importance of rights and users' rights: the right to have one's own living space, regardless of the nature of one's disorder, the right to have an active and productive role in society and the recognition of differences of gender, culture and ethnic origin. However, citizenship, which involves the relationship between the state and the individual, mediated by a civil society which provides the framework of meaning (Janosky), remains a concept linked to welfare systems (Rowe) and their guarantees. With respect to **citizenship**, T.H. Marshall makes a distinction among legal, political

and social rights, stating that the first two are often ignored. While remaining an important frame of reference, this concept should be integrated with other approaches that take their departure from a verification of fundamental human rights.
The Ottawa WHO charter lists the following fundamental rights: "Peace, housing, education, food, income, a stable ecosystem, a constant supply of resources, justice and social equity". Any health model based on these rights must therefore act on the environmental conditions which 'produce' illness (F. Ongaro Basaglia).
Well-being means acquiring the ability to 'function' (understood as a state of being or doing) and the ability to function is the freedom (meaning: real opportunities) of obtaining well-being. This signifies leading one sort of life instead of another, achieving one's goals and having the ability to choose (A. Sen). To the extent that it is viewed in connection with these concepts, citizenship should be interpreted as a social process that brings about individual and social transformation; and thus not a status but, once again, a 'practice', a practice which is essentially the *exercise of social rights* (De Leonardis). Hence, it involves a re-distribution of power, and the exercise and development of capabilities.
The Charter of European Rights (with which the individual mental health legislations should be brought into accordance) seems to propose these issues at another level. However, the current situation in Italy, with a series of proposed bills which intend to reverse the process of deinstitutionalisation, shows that we must be duly cautious before considering the acquisition of rights for psychiatric patients as something definitive.

The WHO's aim of **reducing vulnerability** (Geneva, summit 2000) provides for increasing the coverage of the population by means of interventions which empower the community, while improving access to basic services. In fact, vulnerability 'results from social factors that adversely effect a person's ability to exert control over their own health. Vulnerability is therefore influenced by the interaction of a wide range of factors, including personal factors, factors pertaining to the quality and extent (coverage) of prevention, care and social support services, the environment, as well as social factors such as the legal framework, social practices and beliefs'. Its reduction 'implies that individuals must become active agents of social change in order to escape from a situation which 'victimises' them. In order to strengthen the capacity for adaptation, both resistance, or the ability to withstand external pressures, and resiliency, or the ability to recover from various types of negative impact, must be strengthened' (WHO-WMC, Tunisia, 2001). Among the actions we can highlight here are networking and the enabling of local community participation in order to ensure "social mobilization".

Management and enterprise as the world's yardstick

Instead, western health systems are moving away from deinstitutionalisation and towards an 'enlightened' business management style.

[2](1) At present, the service network in Trieste is made up of 4 community mental health centers (CMHC) with accommodation (8 beds each) for an average catchment area of about 60,000 inhabitants each. Their tasks consist in day and night hospital treatment, crisis intervention, prevention and health education activities, out-patient treatment and home visits, rehabilitation and social activities, social welfare services, cooperation with local health, welfare and legal agencies. In addition, there is a psychiatric first-aid station in the general hospital (which generally does not admit patients, but refers them to the CMHC) 11 group-homes within the city and on the grounds of the former mental hospital, 11 co-operative societies, several workshops and art laboratories for rehabilitation purposes.

With respect to the managerial development or transformation of health systems (which can be seen as an unavoidable prerequisite for rationalization), I think we must continue to maintain a critical attitude and not simply accept these developments as inevitable and a given.
The institution is now described as an 'enterprise', but is this necessarily a good thing? Can a well-managed operation, even if strategically oriented (for example, bringing products and producers together) bring to the fore, as an anti-institutional practice, the contradictions between ideologies/values and practices? Management, which is based on the decision-making of top managers, is antithetical to participatory processes and the production of consensus. What form of rationality suggests itself? We know that *strategic action* conflicts with *communicative action* aimed at getting the actors to agree among themselves (Habermas). Instead, it seems to us that a form of systemic rationality intended to govern complexity has once again begun to prevail (Luhmann).
Achieving consensus results from efficiency directed towards an overall result (outcome) and not from a process, the paramount importance of which should instead be defended. In this perspective, management by objectives (MBO) appears as a form of rationality which is inefficient and totalitarian, while the "matrix model" is a parabola of inter-personal dynamics based on conflict and competition. Every operation, even if defined in a framework of 'continous quality improvement', finds its rationale in itself, and not in possible controls *outside of itself*, in the community. In this way, the homeostasis of the institution is renewed, for the purposes of self-reproduction.
Only sense-making (Weick) permits us to believe in organisational models. But this is not enough: strong values and guidelines are also necessary.

Instead of trends based on rationalization, the term ***social enterprise*** represent a possible alternative that mobilises and involves social subjects and resources. As Rotelli points out, it is increasingly clear that the inadequacy of resources for effectively realizing the principle of universal rights, while still a problem, can no longer be posed in the same way it was when the crisis of the welfare state first began. Even in developed countries the problem still seems to be the lack, or apparent lack of resources. But perhaps it is more a question of why such resources remain unused or of how they are used, ie. for the functioning of institutions seen as (often violent) instruments of social control: prisons, asylums, juvenile jails.

A "social enterprise" strategy should seek the widest possible extension, and not be limited to western countries only. It should reconvert and re-utilise the human and economic resources of the mental hospital in community services; solicit and encourage the local administration in delivering resources directly to users (benefits, job-wages, housing); promote the identification of other resources (institutional, N.G.O.) and collaborators present in the social environment; create productive, integrated cooperative societies that combine diversified job opportunities and vocational training with user involvement in the economic and decisional structure of the various enterprises. In this way, it can bridge the gap between the labour market and welfare systems, and provide an alternative to services which are inefficient, ineffective and unproductive.

Conclusions

This is a *network of organisations*, and thus of situations and experiences which wish to have an impact on the communities where they operate, and beyond, by encouraging

virtuous processes of aggregation. This network is definitely committed to helping all those who are initiating a process of transformation. We also are counting on the fact that a trans-national network will stimulate the creation of informal national networks which can represent and strengthen the mental health movement in the countries in which they operate.
This network must immediately provide support for those situations which are weakest. There are situations in Europe, especially in Eastern Europe, which must be sustained. There also exists a 'spotted' situation in many countries, where small, local experiences, which are slowly making progress, will be supported.
From time to time, individual members of the network will be called upon to intervene, based upon their abilities, the experience they have acquired in particular sectors, or in innovative practices and certain aspects of services. This will take place in partnership with the WHO, but also with other international organisations, beginning with those that collaborate with the UN and which primarily intervene in the most difficult situations [3].

Given the enormous problems and challenges we face (which we have only alluded to here) and the international dimension required in order to orient oneself with respect to a certain kind of globalisation, a Lilliputian strategy, such as the one outlined by Brecher and Costello (1995) appears as both the most opportune and full of opportunities for a network such as ours. Such a strategy means connecting

1. *individual with collective interests*
2. *the global with the local*
3. *North and South*
4. *Individuals across borders*
5. *Specific identities with broader communities*
6. *Social problems and members of society*
7. *Who is threatened with who is marginalised*
8. *Different sources of power*
9. *The various forms of opposition to contested institutions*
10. *Resistance with institutional change*
11. *Economic issues and democratisation*

[3] Gli aderenti a questa rete si dovranno porre a disposizione dell'OMS all'interno di quelle che sono le sue 6 aree di competenza (Nations for Mental Health):
1) assistere i governi nel formulare programmi nazionali di salute mentale;
2) migliorare l'accessibilità, l'organizzazione, la qualità e l'adeguatezza dei servizi di salute mentale;
3) migliorare la rappresentanza e la tutela dei diritti umani fondamentali per i pazienti con disturbi mentali;
4) tener conto dei punti di vista degli utenti e delle loro famiglie nel prendere decisioni sulla salute mentale;
5) promuovere la salute mentale e prevenire i disturbi mentali soprattutto nei bambini, negli adolescenti e nelle donne;
6) assistere le autorità nell'istituire speciali programmi di salute mentale per le popolazioni indigene, profughi e persone comunque sradicate.

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