DEINSTITUTIONALIZATION AND COMMUNITY: A POSSIBLE RESTITUTION

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BUILDING BRIDGES CONFERENCE, Auckland, 29-31 March 2000

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An operational format or criteria for deinstitutionalisation?

Any innovation in the field of mental health cannot help but take into account the fact that it is necessary to examine related problems through an analysis of the institution, beginning with the obvious consideration that the institution orders needs, gives them form and, in some way, also elicits them.

It is for this reason that we must once again insist on the problem of an operational format (for the practical enactment of the legal provisions). In our experience, a service model alternative to the asylum was not proposed and then subsequently reduced to a series of norms for operational criteria, nor was there a choice of priorities beforehand which resulted in the creation of an organisation functional to those choices. The two aspects arose together and developed dialectically throughout the process of deinstitutionalisation.

Certainly, the 24hr service was the format which was invented and which permitted giving form to the innovative practices, while linking them strongly, and with extreme cogency, to those criteria and principles. Only within this framework was the reproduction of certain experiences possible, as well as the creation of further innovations (social enterprise, the aware involvement of users and family members, practices based on gender difference, etc.), which, in any case, had to conform and be coherent with the general model.

However, the creation of 24hr Centres, with overnight hospitality limited to 8-10 beds, was only a step in the process of deinstitutionalisation. Created as a line of defence in the first phase, whose function was to make possible the closure of the psychiatric hospital, the Centres gradually took care of the new demand but also had to evolve before the emergence of new needs, as well as against the risks of sluggishness and inertia, and thus of neo-institutionalisation, which at times began to take form. Their tight-knit format had to relax and open up in order to permit the diffusion of network practices which used them as their point of reference. New

areas of need required solutions which were specific and not generic. In this way, and with great effort, the range of therapeutic and rehabilitative programmes available, as well as community participation, became part of their overall perspective.

In some way, and though with countless doubts, we are now in some way aware that the 24hr Centre is above all a tool, an operational trap, a "armour-plated" mechanism which, in a completely original and unique way, made possible the real superseding of not only the psychiatric hospital, but of a type of knowledge and practice which descended directly from it, up to neo-clinical psychiatry, and which was based on objectifying the ill person through his illness. This was due to the 24hr Centre's ability to combine forms of knowledge with practical solutions based on the imperative to "offer a response" for everyone. This in turn permitted a different way for needs to manifest themselves and gain visibility, in an area between health and illness, and full circle: in the temporal dimension of daily life, in the reality of the community, and in real living situations.
The Centre therefore remains linked to a transition phase. But it also remains the only successful example among the innumerable models and attempted solutions for providing an alternative to the Psychiatric Hospital in advanced countries.
Linking the approach by criteria to defined formats also means creating a connection between institutional places, with their visuals elements, language and culture, and the effective practices which result.

Characteristics of the Community Mental Health Centre.

1. For those of us who work in the community Services, a basic characteristic of such services remains its easy accessibility (in both physical and bureaucratic terms). At the same time, the Service must be a point of reference for the community, that is, it must be credible and have gained legitimacy based on the services it offers to the public, or what we today would call the "comprehensive user" (primary users, but also family members and others).
If we want to take this basic approach and develop it in a coherent way, we must:

a) Be extremely flexible in the ways the services themselves are delivered, and in the Service's communication, both internally and externally, with the user and the community. We must therefore develop what we call a "community style" (Mezzina et al) within the Service. This is possible only through a collective work organisation, which develops relationships horizontally between operators, operators and the comprehensive user, and also within this latter group;
b) Seek to integrate social and health responses, the specifically psychiatric with the non-psychiatric (anything which might be useful for solidifying and developing the ties with the community and its culture), contaminating them with one another;
c) Develop within the Service a multiplicity of "receptors" for the demand which corresponds to the extremely diversified nature of this demand as it exists today: new and old users, the demand for treatment and social emancipation, health information and education. This means diversifying the Service's functions and the operator's abilities in the widest possible sense (not just in terms of professionalism or institutional roles) so that they can function as true "receptors" for this demand. This means that one must provide not only for a specifically "clinical" entry of the demand into the Service, but also open up other possible points of arrival for all those problems and needs which inevitably end up at a public agency which is situated at the point where many existing social contradictions intersect.

In this regard, we can cite Goldman in a NIMH report on the community services in the United States, in which he states that the fundamental innovative element in such services is the recognition of the diversity of needs which underlie the psychiatric demand, versus the rigidity of the "old-style" responses offered by traditional psychiatry.
In our experience, this situation requires developing a new organisational style, as opposed to the establishment of Mental Health Centres seen as out-patient services with facilities for hospitalisation located elsewhere. When viewed as a whole, such a system sanctions a separation – physical, mental and social – between "inside" and "outside", based on the medical model of the "reparation" of the sick body (Dell'Acqua, Mezzina, 1988).
We therefore see the community Service as a place which is open, without barriers, which can be "traversed" and is not compartmentalised either physically or in its institutional culture; where the "open door" is not just the result of a historical process but connotes a paradigm which constantly challenges us to work within a dialectic of power with the users and remain open to the realities of the society in which we live. A Service established in this way can also deal with mandatory treatments, but with the door always open and the "personalisation" of the various levels of assistance. Such a Service therefore presents itself as both a place for temporary hospitality (beds, open 24hrs) and as a place for people to come together (the users in their relationship with the operators, and in their relationships and their integration within the community and with other persons).

2. As regards the general criteria for intervention by Community Services (Reali, 1987, Mezzina et al.), affirming the Service's responsibility for the mental health of its designated community seems to us a basic point of departure which is not only ethical (or, if one prefers, ethical-political) in nature, but also technical and which necessitates a series of other actions and approaches. These include: articulating a comprehensive response involving both the diversified resources of the Service itself, as well as the activation of other social services; avoiding the practice of a selection based on the "severity" of the demand, and therefore not engaging in any form of referral, either direct or indirect (by not "shouldering the burden" of the demand) to hospitalisation facilities; developing the Service's active presence in the community by "going to meet" the demand and forming relationships with the different individuals and groups (the family, the condominium, etc.) which we encounter in the community in an increasingly numerous and diversified manner in the course of our work; developing interventions which, in the user's interest, contaminate the adjacent institutional circuits, specifically social-health and legal, and engaging in all types of relationships with them.
All of these aspects can effectively transform into practice the idea of the continuity of the Service-user relationship in terms of both time and place: place, meaning the community which includes both daily life as well as the institutions; time, the duration of which is commensurate with the need for care, support and rehabilitation, thereby accompanying both the individual and the community in their evolution and "history". By a continuing relationship we not only mean a therapeutic continuity which, in the final analysis, becomes too restrictive as a concept, but of a continuity in "shouldering the burden" for a situation of personal suffering. Perhaps it is only this which will make possible the unification of prevention, care and rehabilitation, to the degree that they are mediated all together in a Service's practices.
We are aware of the fact that our point of departure was a historical given (Gallio, Mezzina, 1988). In reality, however, the community services arose out of the need to deal with the two issues of crisis and chronicity, that is: the need to reduce admissions to the Psychiatric Hospital and, at the same time, to intervene on the problem of long-term hospitalisation and the "pocket" created by the asylum by means of rehabilitation and social reintegration programmes for the inmates. This

led to an effort aimed at gradually enhancing the resources available, which resulted in the construction of the system of possible options - and thus of diversified responses - which exists today. The Service must be able to create the idea of a therapeutic/rehabilitative "itinerary". "Shouldering the burden" places the user in contact with a series of options which can be used in endless combinations and from which the user himself is able to choose or make other proposals and engage in a therapeutic dialogue. In this perspective, the Mental Health Centre becomes the planning centre, by virtue of its being the "connecting structure" (Bateson, 1984), and the structure which contains within it the continuity of care and the goals/meaning of the therapeutic project, and not merely based on its function of bureaucratic-administrative mediation.

Continuity is therefore an "unbroken relationship of meaning", a therapeutic approach which is based on the life story and on the uniqueness of the recognised demands. And here lies the importance of which recognition models the Service uses, in the context of certain "operational residues" (Piro, 1986). In our view, it is fundamental to take into account the individual's complexity by attributing central importance to the possible and multiple meanings which emerge during a crisis situation, mediated by the actors of this conflict (Impagnatiello, Mezzina).

One of the principal aims of the Service's recognition model is to render visible the framework of needs based upon the shift and flux of the elements which manifest themselves (Derrida's "dissemination of meaning"). This model can therefore not be simply a "clinical" model, which restricts the observation-interaction without taking into account the forms of access – and emergence – that demand may have. It is necessary to "draw forth" the individual's framework of needs through the multiple places for contacts and the persons, institutional and otherwise, involved, and to extend this inter-active observation in time and place (Dell'Acqua, Mezzina, 1988).

In this regard, we must once again emphasis the epistemological cogency of an idea which is "positive": that is, of an idea which overturns the epistemology of the "negative" which has historically always informed a psychiatry directed at the object-illness and instead depart from the user's abilities and "healthy valencies".

If we consider illness as an event which is constructed at that point where the personal-subjective, social and institutional interlock and intersect (Maccacaro, 1978), we are thereby also able to imagine its deconstruction (De Leonardis, 1987): ie. the disassembly of the crisis as an itinerary (self- or hetero-directed) of simplification of an individual existence-as-suffering, and which then comes into contact with the institutional agent, the Service. At the same time, it is necessary to oppose the risk of social "drift" and abandonment (Eaton, 1980), in the sense of secondary and tertiary prevention (of disability/damage). Today, rehabilitation is often talked about while forgetting that the damage/limitation (Piro, 11986) encountered in the ill individual and seen as a "social disability" is often the result of devastating itineraries for which the Service is often indirectly, if not directly responsible. In this perspective, it is our view that chronicity should be reconsidered as both a social and institutional product (Ciompi, 1984).

3. In effect, in our view the 24hr Community Service is not just an additional function of an out-patient service. That is, it is not simple the availability of beds within a community service or in related structures; or the extension of the service's hours; or its operational integration into a night-time on-call service for a given community. Instead, for us the Service signifies a profound change in the operational methods and philosophy of a community service which places the user's crisis at the very centre of its concerns. It therefore not only provides refuge and protection and works for the recovery of weak individuals but, above all, it increases the therapeutic offers and resources available. Such a Service thus provides intermediate spaces between the user and the social reality, as well as places for mediation, recovery and rest. But it does so as a definite alternative to hospitalisation with its practices of removing the user from his

social context, treating unique individuals in a uniform manner and forcing diverse subjective realities into a system of rules and codifications.
In fact, such Services must operate with flexible responses, the involvement of multiple actors in the management of the crisis and the use of multiple resources. It must create a situation where the permeability between inside and outside – the visits, encounters, meetings of the patient and whatever else becomes involved does not delimit the experience of the crisis as a "separate experience", while still offering protection to the person during his time of difficulty.
If one works in the way which we have indicated, it is possible to draw the needs forth and make them manifest, because "lived" time, the rhythms and temporal dimension of our daily lives, and the interplay between "health" and "illness (Basaglia 1981) which is one of its central components, in this way become truly central and can interact in a real, concrete way. The person appears in a mobile scenario where the relationships which structure themselves tend to move beyond the rigidity of institutional roles. Conversely, on the side of the user, this produces a better acceptance of the responses, and produces a less-structured illness (what has been called the "closure" of the illness – Scott, 1967) and thus better psycho-social outcomes.

The dialectics with "the community" in deinstitutionalisation

1. In our view, the community is a place which is either empty or full. It is a place of exchange and of return, but also with its own rules and therefore deviancy, interests, conflicts and, once again, exclusion.
However, the idea of community refers one to a social totality towards which the individual either moves or with which he enters into conflict, given that any community is understood on the basis of the inter-human relationships and the bonds it establishes, its values and rules and, consequently, its institutions and social practices. Historically, communities are linked to local contexts, where identity and belonging are easier to recognise, while in great urban areas, especially if stratified multi-culturally or multi-racially, the sense of community tends to weaken or disappear thanks to the general and transversal elements of mass society which function as the principal points of reference.
On a small scale, community refers to a contracting or gathering around a particular sense of Inside which is circumscribed by the tracing of certain boundaries or limits, ideological, for example, and which may or may not be related to an Outside. In this sense, the small community can be either hetero- or self-determined, that is, it can by defined by something outside of it or it can choose to "secede" or separate itself from society at the moment of its creation.
As regards our specific concerns, "community" is a term which appears primarily in Anglo-American social psychiatry, and in particular in the term "community care", a cornerstone of mental health movements, from the post-war period up to the present day. This term refers to the creation of a living space in order to enhance its potential for help, as opposed to the separation of a total institution. Instead, in the Italian experience of transforming the psychiatric hospital, the term "community" (*territorio*) – as in "community psychiatry" and "community Service", referred more to the actual local physical context and emphasised certain key-elements such as resources, access, networking with other services, human geographies and their policies. Thus, the community as myth in many senses: a specific social place (social context vs. local context) which contains the promise of "health", which can "heal" (re-socialisation, social reintegration), but likewise a place which generates the contradictions that can lead to mental suffering, and which contradictions it can therefore either conceal or reveal.
The therapeutic culture which the community develops within itself, and which forms an integral part of it, cannot avoid a relationship with the so-called "Norm", by "ignoring the

culture of the outside world" and distancing itself excessively from it. This problem reappears in the attempt, criticised by Basaglia, to reproduce in the Outside, in society, the model of the therapeutic community. Society seen "simply as a sum of interactions which can be understood and guided by means of psychological and psycho-dynamic techniques", ignoring the inevitable "questioning of the values and principles upon which the social group in which the illness manifests itself is based and, above all, the limits of the Norm - as that Group defines it" (F. Basaglia & F. Ongara Basaglia, 1970). The Norm should thus be understood not as a "given value" but as a "social product" (ibid).
In fact, in both the community's vision of Outside, as well as that of the institution, the problem of the symmetry between micro and macro immediately presented itself. The Psychiatric Hospital was considered the double of society, mirroring the social conditions and balance of power which sustained it – a pantograph of the social which was realised within it, as if dominated by a systemic rationality. And this, in turn, infected the community, sanctioning a specific ideology of illness and its treatment. Other models of the community, on a small scale, presented themselves outside of the institutions and pretended to escape their conditioning and influence, such as the anti-psychiatric models, such as those established in England by Ronald Laing and David Cooper, a utopia of places where it was possible to complete a "voyage" through madness without pre-established rules, if not those dictated by the free experimentation of those same individuals who were experiencing a state of suffering. And thus the situating oneself outside the real community, understood as a place with rules (the word "community" derives from "cum munis", with rules), considered as the only possibility for emancipation, of salvation for the individual.
The other precedent which the anti-institutional movement in Italy aspired to, that of the French, linked itself once again to the concept of the administrative community: a circumscribed area of the state furnished with institutions, and based on the hypothesis (shown to be mistaken if the asylum was not eliminated) of making it function in a different way and in a direction which was not centred on the hospital, but with the responses provided peripherally. Can the community be a place of prevention?
Exponents of social psychiatry, for example Gerald Caplan in America, began to think of the community as a resource and to organise the social and its possibilities for providing support to the individual by means of networks. Working through networks became a fundamental element in the idea of community care, especially with regards to prevention ("primary"). Caplan states: "In a poorly organised society, the feedback based on the community is probably insufficient and there is a greater need for support systems oriented towards the individual". Such systems were based on homogenous groups (self-help, for example). In this case, communities were indeed conceived or, better, reinvented, in order to stimulate the capacity for healing, both of the person and of the community itself.
In Italy, the criticism of the asylum also produced an ideology of prevention based on direct social intervention, in the community, through decentralised services which would "encircle" the concentrated institutions and empty them from without. The consensus of "social forces", through forms of participation in the choices made by technicians, was intended as one of the tools. But the asylum's cogency and strength and the formidable combination of interests and ideologies which it represented - at the centre of the psychiatric question and on the margins of the community – still succeeded in sustaining it, and would do so until the very end.

2. The history of the experience in Trieste can also be considered as the history of a community, in the sense that a group of technicians which, even though in a very different direction from the therapeutic community – that is, by creating and implementing a conflict among the various approaches and ideas regarding the process of deinstitutionalisation – coagulated and compacted itself by means of a challenge and its identity as a community that was "opposed to".
Even though the activity of transformation was made possible and supported by local political-administrative choices, this process was definitely in violation of existing laws and

social practices, which were based on exclusion. The alliance with persons oppressed by the institution was therefore an alliance "against the community", in the sense that it refused to continue to contain the social misery that this community expelled into the psychiatric hospital, masked behind the definition of illness.
The utopia of that misery being reversed and "poured back into" the community (the mass transgression of the rules of internment as in the case of the famous horse), and thus of its being rejoined to it by breaking through the wall, was a necessary component here.
It involved a transformation from exclusion (guardianship) to the social contract, by empowering and increasing the individual's contractual power, and creating the material conditions for a possible re-entry into the real community.
Crossing the threshold from Inside to Outside was also, and primarily, the movement of single individuals (patients), of single existences. In fact, it is through individual stories that one rediscovers ties with the community (the fisherman who is accompanied to his native town in Istria in order to find his relatives, and then returns again and again until he finally remains). The integration of single individuals in the community sometimes resulted in the recognition of a form of belonging – thereby overcoming the fear of someone who was a "foreigner" twice-over. Sometimes the visibility and especially the circulation of the ill person with the signs of his status of diversity still clearly evident, resulted in scandal or the tracing of invisible limits around him. More frequently, it required a difficult apprenticeship of adaptation, as in the case of normalised persons who were not permitted to have any social visibility in order to be accepted into anonymous condominiums. And on still other occasions there were the conditions for attempting to construct and invent community networks (in council housing or in factories) within which an event – an approach, integration – could occur. The one-room council flats could either offer hope or be the source of an illusion, a ghetto. Against this adaptation (to the norm), this hiding of differences, if not of diversity, were the "wounds in the social" which one discovered in the lives of others, and which one was there to heal. The new forms of suffering often remained within the same contradictions of social life in which they were inscribed, and were joined to the new forms of deviancy (addiction, juvenile distress, the new forms of marginality and poverty): in this sense it was no longer "different from them".

The creation of the Mental Health Centre, together with the process of moving beyond the Psychiatric Hospital, seems to have manifested all of the contradictions involved in moving towards the community. On the one hand, they remain small therapeutic communities "diffused and expanded", which aim at the maximum level of internal exchanges, at the inclusion of family members, at the entry of ordinary people and volunteers and therefore at the extension of the social support network thanks to a "community" quality in the relationships structured within it. They carry the challenge of the institutional dimension of relationships "outside", a quality which is, in itself, neither tolerant nor protective but based on a reciprocity among institutional actors/entities made possible by a dimension of power which is no longer authoritative and legitimised by a form of knowledge. On the other hand, their intention is to develop the therapeutic dimension by presenting themselves as places for coming together and for the democratic participation of ordinary people. Thus the "citizenship" assemblies in the Centres, at their opening, to discuss their meaning and possible use. And then the constant search for the community, in its representational and organised forms (the work with the neighbourhood councils, as places for direct democracy), the first efforts in the area of the specific, the offer of services and meeting places open to all, the many critical stimuli aimed at marginal or alternative cultures.

While this movement was accomplishing its aims and the asylum disappeared, the "effects of the persistence of the asylum" (Rotelli) in the other health structures, in the legal system and social services became visible, as if they had been uncovered by this process. The discovery of the "circuit" of the psychiatric demand was at the centre of the

practices of this period, and was based on the “strong idea” of collective responsibility (of the service, the group providing care) for the ill person, of a therapeutic continuity – but not only – in time and in the social reality, in the community.
In dealing with the community, therefore, an attempt was made to “read” it strategically as a network of institutions (which, in fact, constituted the “circuit”). But it is precisely through the relationship-confrontation with the administrative that the process translated into institutional changes, in a specific, even if empirical, engineering of the new services.
The territory as an “administrative” community was a codified space which had to be contaminated. In this sense, one spoke of the invasion of the community by the services, or of going through the neighbourhood with the “long-term patient slung over one’s shoulders”. “From Inside to Outside” was, as we have said, the movement which was both necessary and coherent with the overall aims. The community possessed, in any case, its own form of truth and vitality, in its self-connotation as a place of power and relationships, as a place for socialising and thus of a possible restitution.
For Basaglia, it was important to open up conflicts, as many as possible, in order to activate persons around human suffering.
The Centres gradually stratified knowledge within the community, based on the interweaving of stories, relationships and conflicts, and as soon as they proposed themselves as points of reference and receptors for the demand, as places for the observation and transformation of individuals and groups.

3. Nowadays, no one seems to want to pay the price for community. Thanks to individualism, psychiatric rehabilitation may one day end up being seen as basically a “repair shop” for the inhabitants of the First World, leaving practices based on networks, research and the collective use of resources to the developing countries.
In Italy, forms of participation, committees, associations, non-profit groups and volunteers are thus a major and important reality.

Here the guiding-value was not only that of solidarity, but the communalisation, or common access provided for the “use-values” produced, something which Social Enterprise then developed more completely. As is known, in summoning the intelligence of the real community or of another community, invented or still to be invented, Social Enterprise presented a cultural challenge with respect to the continuous reiteration of the distance between two worlds, that of production and that of welfare. From the relationship between the Social and needs one progressed to that between the State and the rights of citizenship. The problem thus becomes the possibility of those areas of inequality which psychiatry succeeds in intercepting and revealing entering into a larger “channel”, an area of access to social enrichment. Today, the access to goods and services constitutes the parameters of social citizenship: and in this sense the “social value added” is nothing other than the creation of community.
In the relationship between acquisition and freedom, functioning and ability, ability and opportunity (Sen), the problem of a “return to the community” for each person can be successfully universalised.
It has been said that the process that leads to the creation of institutions “shows that they are the appropriation of functions by a centre due to a need which was based in turn on the distance created between forms of local and general knowledge in certain human societies” (“Institutions”, Enc. Einaudi). But once the need of a centre and of the “general” have been fulfilled, what cannot the process be reversed, with the restitution of comprehensive knowledge back down to the local level? That is, towards the communities by means of the services which are finally part of the community itself, confronting and contaminating technical knowledge with the language and presence of real entities, individual and collective, and recovering a possible sense of community through forms of social and communicative actions within it.

4. Our experience in psychiatric practice of the community as a social reality is certainly marked by profound ambivalence. The real community has often appeared as an ideology or spectre: the plural community which is based on the person and not on individuals, which promotes and solicits mediators of community, has rarely manifested itself as such. For us, this is a difficult reminder that we are still dealing with a critical limit – the deviant – and thus with the restoration to the community of a living portion of it, without which one "does not truly provide" community.
Instead, a possible community can be glimpsed in forms of action, which as sociologists tell us occurs with networks of help and support which appear after negative events. Around the ill person and the Service will appear the community of conflicts and differences, still based on inclusion and, by reflection, on exclusion; a community which still requires judgements of diversity and still feels the need to demarcate deviancy. But where it will also be possible to find proximity and the creation of new awareness.
We can therefore speak of community actions, those which go towards the boundaries, the borders, where the alien, the foreigner is driven.
Thus, it is the very statute of the community services should be reconsidered: we need to ask ourselves again: "what is a mental health centre?" Does its presence still perform a crucial function, for the protection of those who are weak? Does it still pose questions for the community, for its definitions of normalcy, its mechanisms of exclusion and silencing? (though it does so only by placing itself in question, its ability or in-ability to produce health for the community – or simply its ability to "create community").
At times, we have seen in the services that a "creating community" could exist, connected in some way to the social, inter-subjective meaning of events and new relationships between persons, and often transcending the new institution of "community" itself – the service.

Today, the central problem no longer seems that of maintaining the user's social context ("no to exclusion" and thus fighting the institutions that practice or realise such exclusion), but the reduction of social harm and the **creation of itineraries for the production of subjectivity** (networks, pathways), taking into account, of course and in a very definite way, the fact/given of the psychiatric disability which reduces the capacity for access and social opportunities.

What different social positioning of the institution might therefore be possible? Services as potent factors of identification which people might need at certain moments of their lives (so that "recognition" is not just "comprehension" but illuminating a real scenario of itineraries of meaning, and empowerment). Services as a "zona franca" where it is possible to recover the rights of citizenship, and externalise the contradictions and problems inscribed in the individual.
Included here are all those practices based on reciprocity, and which move towards empowerment. But this reciprocity must still question itself regarding all the reified aspects of the specifically "service" relationship (Goffman) and thus of the meaning of the institutional relationship.
The new community institutions can, in our experience, acquire meaning "in themselves" in therapeutic processes precisely because they are places that refer to their own "antitheses" which exist outside of them.
That is to say, they become places for social integration and identification, and thus truly therapeutic, if within them the world outside is valued as the place where the person's itineraries take place. Without this, any operation of "individualisation" and the production of subjectivity would become totalising, and would, in any case, make the individual conform to a code. If psychiatry, and the "illness" which it "identifies" are the destruction of meaning through its enclosure in a code which is the code of power, any re-attribution of meaning (any production of subjectivity) can take place only in the recognition of itineraries and bonds with what is outside of oneself, with

what lies beyond the centre. If the process is, in the end, a form of pedagogy, then the lessons here are to not totalise the Other, to recognise multiplicity and to restore diversity as a value for all.

APPENDIX : SCHEMES

TRIESTE

MENTAL HEALTH DEPARTMENT

FUNCTIONS/ACTIVITIES

- Overnight hospitality
- Hospitality/Day hospital/Day centre
- Out-patient activities
- Home-care activities
- Individual and group therapy
- Psycho-social support/activation of networks
- Psycho-social rehabilitation
- Residences
- Professional training
- Job placement
- Aggregation and free time

PROGRAMMES

- User training and involvement
- Information for family members
- Involvement of GP (“Health tutor”)
- Prison consultancy service
- Prevention of “lonely deaths” (“Amalia” project)
- Suicide prevention (“Special Telephone” project)
- Continuous improvement of quality
- Facilitating itineraries for membership in associations etc.
- Basic and professional training activities
- Promotion of social enterprise activities
- Creative/play activities
- Promotion of self-help activities
- Intensifying relationships with health districts
- Intensifying relationships hospitals
- Relationships with the city’s cultural agencies
- Gender difference and mental health

OPERATIONAL PHILOSOPHY OF THE 24HR SERVICES IN TRIESTE

BASIC CHARACTERISTICS OF THE COMMUNITY SERVICE

THE SERVICE MUST BE:

(a) – Accessible

(b) – A point of reference for - (have "services" that it can offer)

therefore:

- Flexible, informal approach in communication and delivery of "services" (community style: horizontal, collection work organisation)

- Integrated responses - "social and health" (contaminate) (RANGE OF RESOURCES) "specific and non-specific"

- Multiplicity of "receptors" for the demand (in relation to the differentiation of this demand and thus of the responses to it) (Diff. FUNCTIONS AND OPERATORS)

- **No** filters : protocols : bureaucracy

(GROUND-FLOOR SERVICES)

"NEW" STYLE/ORGANISATION

- NON OUT-PATIENT
- NON HOSPITALISATION - (Even if alternative)
(in-out, re-affirms medical model, etc.)

(non-compartmentalisation, etc. physical-mental)

Instead:

- OPEN/ WITHOUT BARRIERS (paradigm/challenge of the open door)

- HOSPITABLE (beds) open 24hrs

- AGGREGATIVE (community style; activities, etc.)

WORK/SERVICE
ORGANISATION (COLLECTIVE – HORIZONTAL)

OPERATIONAL AUTONOMY

means:

NO:
RIGID ROLES/ SEPERATION OF TASKS-RESPONSIBILITIES/ HEIRARCHIES "AS SUCH"

YES:
COLLABORATION/ WORKING TOGETHER/ INTERCHANGEABILITY, PERSONALISATION

GENERAL
PRINCIPLES:
- OPENESS TO USER
- "USER FRIENDLY"
- ABILITY TO "READ" THE MEANING OF REQUESTS AND EVENTS
- PERSONAL INVESTMENT/INVOLVEMENT

CIRCULATION OF INFORMATION

WORKING TOGETHER	GROUP DISCUSSIONS ON "WHAT'S HAPPENING"
INFORMAL DISCUSSIONS	
DAILY MEETINGS	CONSTANT VERIFICATION OF "EFFECTS (FAILURES – INVENTING SOMETHING ELSE)
OTHER MEETINGS	DECIDING "WHAT TO DO" DAY BY DAY

THE IDEA OF THE GROUP

- DIFFERENT SUBJECTIVE REALITIES TO RECOGNISE AND VALUE
    - CULTURE
    - VALUES
    - RESPONSE TO SITUATIONS
    - ATTITUDES

- MUTUAL SUPPORT, “SUBSTITUTABILITY”

- AFFECTIVITY, COLLECTIVE FEELING

- RESPONSIBILITY (SELF-MANAGEMENT)

- INSTITUTIONAL ASPECTS TO OVERCOME (ROUTINE, RIGIDITY, RESISTANCE, ETC.)

PRODUCTIVE DISORDER
(IMBALANCE)
THERAPEUTIC
ATMOSPHERE
AFFECTIVITY THAT
EXPRESSES ITSELF
OPENESS
FLEXIBILITY

= DEALING WITH THE PROBLEMS OF DAILY LIFE
OPTIMUM USE OF PERSONAL RESOURCES

CENTRE = ENLARGED THERAPEUTIC COMMUNITY

- "Diagnosis in psychiatry has, by now, assumed a categorical value, in the sense that it corresponds to a labelling beyond which no action or solution is possible. At the very moment the psychiatrist finds himself face to face with his interlocutor ("the mentally ill person") he knows he can rely on a quantity of technical knowledge with which – starting with symptoms – he will be able to reconstruct the phantom of an illness; however, at the same time, he will have the distinct sensation that – as soon as he has formulated his diagnosis – the real person will have slipped from view because codified in a role which serves, above all, to sanction a new social status."

  F. Basaglia in "What is psychiatry?" Provincial Administration of Parma. 1967, 2d ed. Einaudi – Turin, 1973, and in "Writings, vol. 1" ed. Einaudi – 1981

- "If the psychiatrist wishes to understand and, especially, to have some effect upon the mentally ill person, he finds himself in the position of being forced to place the illness, the diagnosis and the syndrome by which that person is labelled between parentheses, given that the person is destroyed more by what the illness is presumed to be and the security measures which have been imposed by such an interpretation, than by the illness itself."

  F. Basaglia, ibid.

- "Psychiatry's current task could be that of refusing to seek a solution for mental illness as illness, but to approach this particular kind of ill individual as a problem which – only to the degree to which it is present in our reality – might represent one of the contradictory aspects which will require conceiving and inventing new forms of research and new therapeutic structures".

  F. Basaglia, op. cit.

WORKING FOR CHANGE

- **Shutting down the psychiatric hospital** as the criticism of the *practices* of clinical psychiatry and its culture recognising in the end of the great utopia of the asylum the failure of psychiatry

- **Building a network of services which offer a concrete alternative** as research into the *practices* of innovative cultures and procedures which must, in any case, be different

- **The "ill person and not the illness" at the centre of the research for the creation of therapeutic, rehabilitative and emancipatory itineraries** as the construction of *practices* of the active participation of users in the services as actors for change.

SOME INDICATORS OF THE DE-INSTITUTIONALISATION PROCESS

Defining the area of reference
Shifting resources and interventions from the psychiatric hospital to the community

Responsibility (towards the user, context, area of reference)
Re-formulating psychiatry's social mandate within the community framework

"Shouldering the burden"
Times and places, listening, narration, resources

Criticism of the medical (and psychological) model as practice
Giving a relative and tactical role to technical choices

Creating context / history
Shifting from individual to collective action

Subjectivity
Shifting attention from the illness to the person

Giving importance to new actors (natural operators, family members, volunteers)
Involvement and activation of local networks

Group work
Practical-affective dimension of community-based therapeutic/rehabilitative action

Therapeutic atmosphere
"Open door"

Promoting social enterprise
Activating social policies for (re)productive capacities of weak and disadvantaged persons

OPEN QUESTIONS IN THE PROCESS OF CHANGE

Freedom / Responsibility

Institutional make-up (hierarchies) / "Shouldering the burden"

Community / Community dimension of psychiatric work

Affective dimension / Presence of real persons

(*from G. Dell'Acqua "The Italian asylum law. Towards a de-institutionalisation model")*