

# THE TRIESTE MENTAL HEALTH DEPARTMENT

## facilities, services and programs

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### Introduction

In describing the, by now, thirty-year experience in Trieste, we would like to deal in very practical terms with the question of “what to do” in those places where there exists the problem of superseding the psychiatric hospital and building a network of community services able to serve the needs of the population.

In our view, the therapeutic promise inherent in the transformation process of closing the psychiatric hospital and in the progressive creation of community services, which in Italy is sanctioned by the Psychiatric Reform Law of 1978, risks remaining unfulfilled if the theoretical and practical experience of deinstitutionalisation is not recognised as the fundamental pre-condition for such a transformation. In nearly every instance, the community services are without history and are subordinated to the institutions of clinical psychiatry, as if community psychiatry were merely a detached and independent fragment of those same institutions intended for different and separate users.

The deinstitutionalisation phase - defined as the mobilisation of institutional actors, the transformation of power relationships, the reconstruction of personal subjectivity, radical alternatives to internment, the critical reformulation of the various forms of professionalism involved, and the re-conversion and use of resources, including those which are not strictly psychiatric or health-related – is missing nearly everywhere.

These transformations, due to their very real and practical nature and in recognising the fact that there exists a strong link between organisational methods and the therapeutic work (as we experienced most definitely in the psychiatric hospital), have laid the groundwork for building organisations which are fully capable of both receiving the demand and providing adequate therapeutic responses to it.

### The organisation of the Services in Trieste. Description.

The current network of services in Trieste was already operational, with very few variations, in 1978, even before the new law reforming psychiatric assistance in Italy went into effect.

This network was the result of the total re-conversion of the resources of the psychiatric hospital over a nine-year period of working within the actual hospital, and which culminated in its effective and formal closure in 1980.

Today, the Mental Health Department (MHD) guarantees that the psychiatric services and emergency stations operating within the community constitute a **single organisational complex**, thereby avoiding fragmentation and shortfalls and ensuring the close **co-ordination between the services** themselves and **linkage between the community and its institutions**.

The MHD is made up of the following services:

- 1) Community Mental Health Services
- 2) Diagnostic and Treatment Station (within the General Hospital)
- 3) Rehabilitation and social integration structures and services.

The University Psychiatric Clinic is also connected to the MHD.

The staff currently consists of 25 medical psychiatrists and 170 nurses, as compared to 13 psychiatrists and 460 nurses in 1971. There are only 10 psychologists

and 9 social workers. Given that the Province of Trieste has a population of 250,000, there is a ratio of about 1 doctor/10,000 inhabitants and 1 nurse/1,500 inhabitants.

The MHD has its own budget, which is allocated annually. Today, the Service cost is ITL 23 billion per year, as opposed to the ITL 5 billion spent by the Psychiatric Hospital in 1971 (at today's values this signifies a cost reduction of nearly 50%).

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The MHC's work-group is composed of nurses, social workers, psychologists and psychiatrists and it can provide meals to users, either in its own facility or in subsidised public eating-places.

The MHC operates 24 hours a day, 7 days a week. During the night, the operators assist persons in crisis who are receiving overnight hospitality.

The MHC's have the task of safeguarding the public's mental health. They represent real, practical alternatives to hospitalisation and help avoid recourse to the Psychiatric Diagnostic and Treatment Station (PTDS) within the General Hospital.

The PTDS is an emergency psychiatric service. It has 8 beds and provides psychiatric primary care and counselling services for the other hospital wards. It also acts as a filter for the demand which arrives in the General Hospital Emergency Room, and makes referrals to the community mental health services if necessary. If the patient arrives during the night, he/she may be kept under observation and put in contact or referred to the competent MHC the following day.

The MHC's control and manage the PTDS's activities directly and are responsible for activating the community responses as quickly as possible. Even when hospitalisation occurs, which is quite rare, it always takes place within the continuity of the community interventions being carried out by the competent MHC. This prevents it becoming a separate intervention or, worse, an alternative to such comprehensive responses.

Even the Mandatory Health Treatments (MHT) are preferably applied in the competent MHC and not in the Hospital.

The Empowerment, Rehabilitation and Social Integration Service combines and co-ordinates structures and initiatives for the training, empowerment and rehabilitation of users, in an organic relationship with the MHC's and other MHD services.

The work of training and rehabilitation entails creating strategies, obtaining tools, activating resources, implementing practices for the development of autonomy and developing social networks and productivity for users, especially for those with serious mental health problems and disabilities, who must be considered, first and foremost, as citizens with full and equal legal and social rights.

This service articulates its interventions for empowerment among different structures and facilities, which include:

- 1) Residential-empowerment Structures
- 2) Day Centres
- 3) Specialised Coops.

1) On the grounds of the former Psychiatric Hospital there are currently 6 residential structures which host from 3 to 12 guests each, for a total of about 55 guests, the majority of which are ex- long-term inmates of the Hospital itself. Three of these structures require 24hr nursing assistance, due to the typology of the residents,

while the remaining 3 require 1 or 2 nursing shifts, depending on the autonomy levels of those who live there.

There are also 6 group homes in town, with about 50 guests.

2) DAY CENTRES. For users from one or more Community Service, their purpose is to provide a place for the development of educational/training activities, social skills and scholastic learning and for a wide variety of group activities.

They are therefore provided with computers, tools and production materials for expressive activities. In particular, the Day Centre located on the grounds of the former Psychiatric Hospital ("The Polytechnic") has workshops for theatre, painting, graphics, ceramics, serigraphy, music, body expression, computer science, and numerous other sports, games and group activities. The Centre is frequented by users who have not yet been placed in a work activity, and who therefore need individualised programmes aimed and stimulating and strengthening their learning, expressive, emotional and social abilities.

The Day Centres also promote the organisation of professional training courses, and recreational and scholastic activities in collaboration with public agencies and institutions, as well as other individuals or entities with specific teaching/professional abilities.

In addition to health operators, these activities involve the participation of volunteers, escorts and professional operators from various disciplines (artists, actors, teachers). There is thus considerable contact with forms of professionalism and approaches and teaching methods which are very different from those generally found in health or so-called "normal" artistic environments. The participation of non-Service users is encouraged to promote forms of social integration and enhance the quality of the initiatives.

For several years now, "scholastic programmes" recognised by the Public Education Ministry have also been in effect. These include literacy courses for adults who have regressed or who have mental handicaps (30 persons), and remedial literacy courses which also include group and reality-orientation activities. There are also courses of 150 hours each for obtaining a junior high school diploma. These are aimed at young people who have been expelled from school or who come from areas of social marginalisation.

3) SOCIAL/INTEGRATED COOPS: The first coop, which was created in 1973 in opposition to "work-therapy", has since been joined by four other coops. They provide work for nearly 200 workers (40% of whom come from disadvantaged areas) and at the same pay-scales as stipulated by current national labour contracts.

The coops, which also make use of contributions from the European Community, are aimed at starting up work projects, engaging in "enterprise" and competing in the marketplace. They especially seek to involve young people with psychiatric or substance abuse problems, or who have been marginalised in other ways. In addition to their 200 worker-members, the coops also provide training for at least 100 young people who work part-time (20 hours weekly) and are paid through work subsidies. Currently, the coops are involved in 20 different sectors, including cooking and cleaning services for the MHD facilities, a small hotel, a restaurant, a bar, a book-bindery, a construction crew, a moving crew, a carpentry shop producing design furniture and objects, a radio station, a hothouse and greengrocers, and maintenance and cleaning crews for public gardens and facilities.

The MHD also supports the job training and placement of users within the various coops by means of its own personnel and by providing for the free use of its own facilities, equipment and vehicles.

## **A comprehensive look at the services provided.**

The MHC's actively support or provide the following range of interventions:

TOTAL OR DAY/NIGHT HOSPITALITY, or the providing of temporary shelter in a MHC to whoever may need such assistance.

VOLUNTARY HEALTH TREATMENT IN HOSPITALISATION CONDITIONS in the Psychiatric Diagnostic and Treatment Station (PDTS), the University Psychiatric Clinic or in other general hospital wards. Such treatment is applied only in those cases where an intervention outside of the hospital, as provided for by law, is not possible. It remains, however, under the control of a MHC.

MANDATORY HEALTH TREATMENT, which is applied in a MHC or in the user's home or, when necessary, by hospitalisation in the PDTS.

DAY HOSPITAL/HOSPITALITY, carried out in the MHC or in one of the Department's residential or semi-residential structures. Meals may also be included.

Day hospitality is proposed for cases where it represents an alternative to day-night hospitality or hospitalisation, or in intensive rehabilitation programmes.

Out-patient and home visits may be medical and/or psychological, and of an emergency or non-emergency nature.

OUT-PATIENT VISITS include the first contact and/or referral of a case; the exchange of information and opinions with the user and/or their family members; the verification of therapeutic programmes; the verification and control of drug therapies; counselling in emergency situations; examinations for medical certificates and specialised medical reports.

The purpose of HOME VISITS is to contact the user and/or his family or other persons involved; to verify and intervene with respect to living conditions; for crisis interventions, when and where possible; to administer, control and verify drug therapies; to accompany the user from his home to hospitals, public agency or elsewhere, and in order to learn more about the person's real living situation.

By INDIVIDUAL THERAPEUTIC WORK we mean repeated, programmed meetings and discussions with the user of a psychotherapeutic or counselling nature.

By GROUP THERAPY WORK we mean programmed meetings with groups of users (including family member groups) which are therapeutic in nature or for the promotion of self-help and health education.

By FAMILY THERAPY WORK we mean programmed meetings of a psychotherapeutic or counselling nature with the user's family members.

INTERVENTIONS FOR THE ACTIVATION OF THE NON-FAMILY SOCIAL NETWORK are aimed at those figures which are significant for the user, such as friends, co-workers and neighbours, in order to involve them therapeutically, and for support and social integration.

The Services carry out CONSULTANCY ACTIVITIES with all the health structures and other institutions in their area.

The Services are required to promote SOCIAL-WELFARE INTERVENTIONS (DIRECT OR INDIRECTLY THROUGH THE ACTIVATION OF OTHER AGENCIES). These include: paying subsidies, home living support, managing residences, providing meals, overseeing, in accord with the user, the management and administration of their possessions and financial resources, managing leisure activities, day trips and holidays, social-therapeutic and group activities, etc..

Each MHC promotes REHABILITATION INTERVENTIONS AND JOB TRAINING, PLACEMENT AND SUPPORT ACTIVITIES and provides cultural and informational access.

With respect to rehabilitative functions, and specifically in the RESIDENTIAL area, the Services promote forms of co-habitation among users and group-homes.

## **Macro-indicators.**

The average number of persons who contact the Services each year is 12 per thousand. Private structures and specialists are used by a very low percentage of the population and there has been no evidence of trans-institutionalisation.

In 1977, one year before the reform Law, the number of mandatory hospitalisations reached a high of 177. Today, the number of Mandatory Health Treatments has stabilised at around 20 per year (or 7 per 100,000).

Turnover has increased with respect to 1971 to about 3,000 contacts annually (as opposed to 1,600 in '71), in a total population of 250,000 (310,000 in 1971). Users no longer come almost exclusively from marginal or disadvantaged social groups, as was the case with the Psychiatric Hospital when nearly 97% came from disadvantaged groups, but from all social classes.

There has been a definite reduction in the number of patients who have been referred by the Judiciary to Forensic Hospitals following a psychiatric evaluation, from 15 such referrals in '77 to less than 30 total in the 20 years following the Reform Law. Today, there is 1 Trieste's resident interned in such a structure.

The number of suicides annually, a figure which is above the national average, has changed in the last 4 years. From an average 22 per 100,000 (1978 - 1997) to 17.9 per 100,000.

There has been no increase in crimes related to mental illness following the shut-down of the Psychiatric Hospital.

There are no longer requests for "internment" by family members.

Shock therapy and physical restraint were abolished at the very outset of the transformation process in the Psychiatric Hospital.

Costs for psycho-active drugs represent 0,5% of the budget.

## **The need for a "strong" mental health service.**

Let us now look more closely at the 24hr Mental Health Centre, that "device" which was invented and constructed piece by piece and which represents the fulcrum and axis of the entire community work, functioning as both the operational "brain" of the system and the place where the new therapeutic responsibility is put into effect. This approach made it possible to avoid the fragmentation of community structures common to nearly all examples of this service model, where recourse to hospitalisation has become the new centre of the system.

Based on evaluations of psychiatric assistance in Italy today, the general tendency to divide the psychiatric problem between an out-patient approach and the culture of hospitalisation, between a "technicalisation" of the community and abandonment appears as generally confirmed.

In accordance with the well-known "hydraulics" of the circuit, the user pool recirculates continuously, thereby overwhelming the Diagnostic and Treatment Services which become incapable of dealing, even minimally, with an emergency situation and the pressures of a cyclical, or "chronically acute" demand. The community services, conceived as out-patient services, inevitably accept a subordinate role with respect to the hospital services, thus exercising an insignificant role, with minimum impact upon the psychiatric circuit.

Emphasising the centrality of the community is therefore not enough. Instead, strategies must be enacted which attack operational models based on hospitalisation, and real alternatives must be conceived and realised which are articulated over time and co-ordinated among themselves.

The Mental Health Centres in Trieste thus have the task of structuring the therapeutic work by situating it in an integrated group of responses which can provide an individualised therapeutic programme for each user. This approach derives from the

awareness acquired during the anti-institutional process that the nature and value of the therapy provided is the result of all the actions of a service taken together, the relationship which it establishes with the user and its passage through the institutional contradictions which, even in a community service, tend to reproduce themselves: the contradictions between abandonment and control, care and control, therapy and emancipation, autonomy and dependency, institutional inclusion and liberation.

The decision to create the 24hr Mental Health Centres in Trieste essentially confirmed the need for making the community-based response – and not the alternative of the Diagnosis and Treatment Services - central to the new Services, through the construction of a “cogent” model which would compel the operators to adhere to a certain approach and sense of responsibility. In fact, this model declared the Service’s intention of being self-sufficient and prevented all possible forms of referral or “passing the buck”. At the same time, the Service had (and has) no intention of becoming a “small ward” and modifying its therapeutic approach with closed doors or limited access to the community.

The Centres can also be seen as the further development of practices which were already in use and which were linked to the reorganisation of the wards of the Psychiatric Hospital on a community basis, each with its user catchment area and own system of admissions and release. From the outset, they were situated in the context of superseding the psychiatric hospital, and were an essential and necessary factor and tool in that process.

It was imperative that they assume full responsibility for the demand, that they be able to “shoulder the burden”, but without totalising and by means of therapeutic projects which were both individual and community-based. Direct responsibility was thus given to the local “equipes” for their given area.

In order to become a credible alternative to the indiscriminate “collector” of the asylum, the Centres also had to represent direct points of reference and offer immediate accessibility. Certain important functions of refuge and “asylum” also had to be maintained, those positive aspects inherent to accepting the demand such as the possibility of rest, recovery and a temporary distance from those contacts which erode and destructure the user’s, and his family’s, sense of integrity and wholeness

Today, the 24hr Service still seeks to prevent the practice of psychiatric hospitalisation (in the PDTS and elsewhere). This approach is contrary to that practised by most of the Services created in Italy after Law 180, because it is the community itself which assumes direct responsibility for crisis situations.

In our experience, the 24hr Service is a formidable tool for responding to crisis precisely because it can activate in a critical and immediate way a series of resources, it favours a closer approach to the person who often has a fear of psychiatry or the attached stigma, and because it can produce an immediate network of relationships which are important for the individual during the course of the crisis.

When a Service is conceived in this way, the crisis also has the potential of exerting a positive action on the context, because it is seen as occurring within a group, a network. By proposing diversified levels and the decentralised and expanded therapeutic response which only a community-based Service is capable of putting into action, it is possible to activate resources which hospitalisation is incapable of. The potential for transformation inherent within the crisis can thus be realised by decoding its demands through the confrontation and mediation among different viewpoints and needs.

By extending the Service’s response over a virtually infinite range of occasions and possible durations (from the out-patient or home visit, to the informal meeting, to the day-hospital and 24hr service, but always in a context of interventions both inside and outside of the Service) it is possible to gradually produce an implosion of the demand for medicalised hospitalisation. Rigid demarcations no longer exists: there is no longer an inside and an outside nor, in certain sense, a beginning and an end, a before and after. What remains constant in this model, however, is the need to direct

in an extremely detailed and precise way, and to negotiate and openly express the reasons leading to the decision to provide hospitality for someone in a Centre. This occurs especially in the handling of the majority of the Mandatory Health Treatments within a Service which is also open to other interventions regardless of how difficult or full of conflict they may be. This approach, however, encourages direct encounters and confrontation and renders immediately evident the conflicts of will and decision-making that often constitute the underlying reality of a MHT (and not the seriousness of the psycho-pathological situation).

The need to distance oneself from one's own living environment (a decision which, each time, involves a process of agreement, awareness and conflict) takes place in an operational reality in which an open, transparent and permeable Service permits the relationship with that environment to continue while creating a dialectic with it.

The hospitality provided by an open Service will therefore never have the clinical character of labelling and definition, of a total delegation to psychiatry ("dumping"). Instead, it will have a community character based on shared responsibility (among user, service, family and other users who will provide support) and the constant search for agreement. It will be based on continuous availability and without closure in a definition of "illness", on therapeutic exchange and the inclusion of both inside and outside in the therapeutic context (the user can go outside, though perhaps accompanied, may go back home for a period of time, request the response to immediate needs, etc.). This form of hospitality will thus be situated within the continuity of a project, of a before and after, of which it will be a temporary and passing moment.

Above all, dealing with the contradictions of a "stay" within a 24hr Service permits the decomposition of the needs that underlie the hospitalisation-mode in mental health, and thus renders these needs visible, manifest. We know how these needs were annulled by the psychiatric hospital and how they are likewise generally nullified by the formatted responses of the Diagnostic and Treatment Services.

Instead, in a community Service, the "bed" can be used in a flexible way, depending on the need for institutional protection of the most varied user-types. Hospitality can be used to provide refuge for one night only, or as a response to the institutional "impasse" of a difficult user who sometimes has to wait for months for the activation of other possible solutions (group homes, returning home, etc.). In these cases, the 24hr Service becomes the fulcrum of a rehabilitation programme in order to prevent forms of chronicisation.

The Service should be seen as an area for daily exchanges (see below) and the elaboration of personalised programmes, the identification of living solutions – which are never final – and solutions for cohabitation, as well as access to training projects and forms of social stimulation.

Community Services conceived in this way make it possible to view needs in an articulated way and relate them immediately to actual living situations. It becomes possible to work continuously against the risks of mechanistic therapeutic responses and fragmented therapeutic itineraries, and the danger of social "drift".

The articulated, phased approach is able to impact on the assembly of the psychiatric demand itself. There is a secondary effect of transformation, beyond the practice itself, upon the community, and on the ways the psychiatric demand presents and expresses itself (patho-plastic). It tends increasingly to modulate itself with respect to this willingness to help, while the fear associated with psychiatry, coercion and invalidisation – which is a sort of aura/reverberation of the demand – on the contrary tends to diminish and disappear.

## **Operational philosophy: criteria and rationale of community therapeutic practice.**

The “criteria” or general operational principles serve to define and describe the system of reference, the guidelines, one might say the “values and purposes” of such an operational approach.

In this sense they are useful, beyond the real, practical experience being discussed, for suggesting orientations and priorities which must then be converted into coherent operational and strategic actions, and into “procedures” which can be described.

In our view, it is absolutely necessary to affirm and practice in a very real way the Service’s responsibility for the mental health of its community of reference. This seems to us a fundamental starting point, and not only in ethical (or ethical-political) but also technical terms.

The Service’s responsibility must expand from a specifically technical context to include an attitude which is actively directed at the promotion of occasions and tools for mental health in its own catchment area. What happens within that area must always in some way be the Service’s “business”, though without it then attempting to “cure” the problem by sequestering and separating it from the community. Instead, responsibility presupposes the community’s participation; the presence of the psychiatric technician alludes to this other, collective presence, and is a stimulus and point of reference for it, a pole of aggregation. The responsibility for the mental health of the community moves towards openness, the outside, is restitution and enrichment and not an institutional enclosure and “shutting-in” of the inter-subjective and social contradictions which exist within it.

In this sense, the movement into the territory through community services is not intended as a form of diffused institutionalisation which has as its sole aim and purpose the treatment and precocious assumption of distress and suffering as a *pre-institutional* object, but is predicated on the idea of the social integration of diversity through the production of emancipation, the possibility of recognising differences and the right for such diversity to exist.

This leads necessarily to the articulation of a comprehensive response through a diversification of the Service’s own resources as well as the activation of other services, and through a wide-ranging integration of health and social responses, and therapeutic and assistance resources. It also means enhancing and giving value to the resources present in the user’s own living situation and requires the integration of non-professional and voluntary work (including that of family members) for the purposes of rehabilitation and social integration.

A comprehensive relationship with the suffering of the ill individual can thus be formed from the very outset if the models used to recognise suffering are based on the request for help and an understanding of the complexity of the user’s situation. The intervention will reveal progressively the framework of needs, situating the individual once again in an historical-personal perspective and within a social network, and attributing possible and collective meanings which are mediated among the actors of the conflict.

An intervention of this kind thus tends to detach itself increasingly from the rigidity of the medical model. Ensuring other possibilities for living, alternatives however limited, and the possibility of choice are thus among the Service’s aims.

However, in order to achieve these aims it is necessary to provide the Service with adequate resources. By resources we mean material aids, direct and indirect services, places and opportunities for socialising which are used for each given case

as an offer in the context of the individualised therapeutic project and which must be integrated in various ways with what can be more readily defined as “specific”, “health” and “technical” actions.

The wide range of the resources available is the result of extending deinstitutionalisation to the administrative level, and thus to the way in which public resources are distributed. The operator is called upon to orient these choices in relation to practices that each time “anticipate” and experiment changes in the quality and differentiation of resources, and which then become useful indicators in administrative terms (for example, the question of housing solutions, the transformation of subsidies in directed subsidies and finally their conversion into job training subsidies, the promotion and creation of cooperatives, etc.). The resource must then be “customised” for each given individual project and made “productive” with respect to the increase and shift in living levels.

New resources are created through initiatives of aggregation and self-aggregation which are encouraged by the Service, users and ordinary citizens (see “new subjects” below and the co-operatives). In this case too, material resources are the necessary condition for creating the possibility of new relationships and new networks of relationships, and for exiting from the repetitiveness of individual destinies and situations. We see resources as developing opportunities of support, protection and social security for the user. They must address a very wide range of needs and aspects, which include: the housing sphere (setting in order, cleaning and maintenance of one’s home, alternative living situations, whether autonomous, with other users or in group homes); income and finances (subsidies, legal protection of possessions and financial assets and the temporary management of finances); food (canteens, home delivery of meals); self-care (clothing, personal cleanliness, laundry, etc.); work (co-operatives, work subsidies, assigning of odd jobs, etc.); free time (organisation of group activities, groups of young people, day-trips, out of town trips and stays, parties, occasions for contact with the community, creation of artistic, theatrical workshops, etc.).

A Service’s independent resources, and thus its “use value” for the user, does not mean that it cannot activate outside resources. Such resources should be sought together with other social services and, if possible, be modulated and “contaminated” in order to adapt them to the individual project (indirect services).

These aspects therefore constitute an important element in psychiatric practice today. Yet they are neither reductive as in the “social approach” which situates itself alongside the nucleus of distress and suffering in order to administrate it and fragment the comprehensive nature of the needs being expressed, nor can they be considered as the “social aspect of medicine” or the entry of social needs into the clinical area. The activation and use of a resource is an action/commitment by the operator which presupposes a “being with” and a “going with” the user, and which mediates a real therapeutic exchange and makes a relationship of trust possible. In this process, the user’s contractual capacity is strengthened and he/she re-enters into the social dynamic, is once again “put into play”, thereby opposing the phenomena of “social drift”, impoverishment and marginalisation which are linked to illness. Resources are thus validated by the Service’s ability to organise them and articulate their meaning with respect to the user, as opposed to treating them as elements independent of the therapeutic practice.

However, the community service must be aware that it is impossible to completely plan an intervention, and that any response is provisional and contingent in the sense that meeting certain needs and supplying certain elements that were lacking will cause other needs to emerge. It must therefore remain flexible and prepared to change with respect to the limits indicated by the user if it wishes to avoid the user “falling to one side” of the therapeutic project.

In our experience, it is still necessary to avoid any selection based on the seriousness of the demand which results, either directly or indirectly (by not assuming

responsibility), in referrals to hospitalisation facilities. The Service should instead aim at becoming the principle (or sole) referent for the overall psychiatric demand. It must not refuse an “impossible” problem by referring it to other institutional structures, thereby accepting a scale of seriousness for users and thus for “treatments”.

The declaration of psychiatry's non-competency is another aspect of the problem. That is, in trying to avoid the fate of the old asylum of being the collector of all the rejects of the social-health system, or of whatever is incompatible with the rigidity of the medical or welfare systems, the Services often refuse a “dirty” demand. Instead, a proper practice means operating within a framework of shared responsibility and the activation of projects in collaboration with other actors in the social-health circuit. This creates a dialectic concerning the problem and prevents its return to the psychiatric circuit. Ultimately, it defends the right to care for this disadvantaged group while avoiding their expulsion from the Services. Operating according to rigid definitions of non-competency instead leaves the person to fall between the cracks, the crevices and interstices that exist between the various services, once again producing abandonment.

The Service must also develop an active presence in the community by “going to meet” the demand, and by engaging and forming relationships with the individuals and groups (families, condominiums, etc.) encountered increasingly and in ever more diversified ways during the course of our work. This active presence and the mobility towards the demand also helps avoid emergency waiting lists and bureaucratic filters, and promotes the approach of “shouldering the burden” in those places where persons live their daily lives.

By considering itself responsible for the mental health of its own territory, and by eliminating bureaucratic filters, selective procedures and waiting lists, the Service already goes to meet the demand, for it creates the conditions for the demand to arrive in the most direct, varied and informal ways. The issue of whether the Services should be first or second level is obviated by making a priority of this “going towards”. Being ready to intervene and reducing the latency time between request and contact is not enough. The problem is what type of service is being offered and the way in which the real needs which manifest themselves in a given area are identified (the reality of needs).

All of which can effectively transform into practice the idea of a continuity in space and time of the Service-user relationship: spatially, and thus in the community, seen as the place for living and where the institutions are located; temporally, in the sense of periods which correspond to the need for care, support and rehabilitation, thereby following the progress and history of both the individual and the community together. By continuity of the relationship we mean not only a therapeutic continuity (which when used to refer only to a relationship between the same team of operators and the user and the continuity of the services offered over time seems to us too restrictive), but the continuity of “shouldering the burden” of a situation of suffering. Only this may permit us to one day achieve a unity of prevention, care and rehabilitation, in the sense that they shall all be mediated through the Service's practices.

The places where the community Service carries out its therapeutic relationship with the user, the settings for “shouldering the burden” must be multiple (though we believe that the Mental Health Centre must continue to propose itself as the place that receives the demand). We are thinking here of the many locations which make up the user's daily routine (home, work, bar, etc.) and where the Service can meet the user. In this way, the Service operates both inside and outside of its own physical confines, and in an operational continuum. Seeking out the user and recognising the value of his daily life also means interpreting and traversing the community through the user's personal history and itineraries.

Institutional itineraries also appear as fundamental, because it is in the social-health circuit that distress and suffering become codified in a psychiatric demand which then finds (or does not find) a response. The Service's imperative to attempt to control the circuit imposes itself here because it is the only way to see/interconnect and modify/contaminate the complex institutional apparatus which influences the constitution of suffering as a psychiatric demand. Controlling the circuit also means providing prevention. Here and elsewhere it makes more sense to refer to the "circuit" rather than the "community" because the circuit's map is identified with the demarcations of the various institutional areas that compose it and with the distribution of power among its various judicial, administrative, economic, political and social declinations. The intervention must therefore contaminate the adjacent institutional circuits (esp. social-health and judicial) in the user's interest and engage as fully and widely as possible with them.

The Service must be willing to follow the user even when he/she abandons the therapeutic setting and is exposed to sanctions. Here too, the prison and forensic hospital must not be alien to the Service. They must be seen as places for the recovery of those users who end up there, and as indicating limitations in the relationship which must be understood and overcome: limitations of non-comprehension, ineffectiveness, abandonment.

Assuming responsibility thus leaves no alternatives: the "difficult" demand is destined to return, through continuous feedback, to the Service, which cannot define the "end of therapy" in a rigid manner. The type of practice which develops shall be synchronic and not diachronic, and the concept of "treatment" followed by release shall no longer exist. Instead, there will be a sequence of points and moments of contact, which can be interrupted and resumed in accordance with moments and periods of tension. And because there are no appointment books and waiting lists, the ability to "receive" the demand can expand to a critical juncture, and then regulate itself and activate alternative pathways.

### **The Service's social quality: a community style.**

Working in équipe is fundamental to maximising the Service's human and professional resources. It means enhancing and valuing each operator's contribution through the assumption of specific tasks and responsibilities within a proper relationship of inter-dependence and operational autonomy.

Working in équipe also means the widest possible circulation of information, the formulation of therapeutic projects through multi-disciplinary approaches, the co-ordination of interventions in collaboration with diverse professional figures and the constant training and updating of the équipe itself.

One of the most evident products of deinstitutionalisation, and also one of the most powerful factors for change, was the criticism of the rigid, compartmentalised and hierarchy-based work organisation of the psychiatric hospital. This order was maintained thanks to repressive mechanisms which contained the potential of subjective energies in favour of highly uniform, repetitive and de-qualified approaches and procedures. Today, thanks to deinstitutionalisation, there is a tendency towards a totally different community organisation based on working in équipe, the enhancement and valuing of the single operator's resources and much more widespread communication.

In our view, this is one of the most problematic yet least evident aspects of the debate on the Reform Law and the new Services. The internal organisation of the Services, precisely because overlapping with the "intervention" and the "strategic" question of the Service's place in the circuit (LABOS, 1987), represents the crucial point of the entire transformation process because, if left unresolved, it makes any effective flexibility impossible.

The question of organisation is central to the conflicts concerning the roles and knowledge of the various disciplines. This, in turn, must lead to a profound re-evaluation of the specific professions involved, and out of this readjustment and new contractual basis innovative work-styles will hopefully be created. "Hospital" organisation, on the one hand, and "out-patient" organisation on the other, indicate once again the maximum rigidity of behaviours and closure of the system/service, and thus the maximum dispersion of human energy (under-utilisation, demotivation, burn-out).

However, a Service which operates according to the criteria presented thus far cannot help but consider the mobilisation of such energies as of primary importance in terms of emotional investment, expectations for transformation and subjective involvement, and especially with regard to its basic operators.

This is what "working in *équipe*" should mean: not just a multi-disciplinary approach due to the juxtaposition, adjacency and division in the various work situations and contexts, but a system of continuous exchanges and the recovery of individual professional and personal contributions.

However, this value given to the single operator as a human and technical resource is not the result of service assignments or a mechanical division of labour. Instead, as in the case of the transformation of the psychiatric hospital, it is the result of a re-negotiation of power(s) among the various professional roles, of degrees of responsibility and operational autonomy. This autonomy must be constantly verified by the *équipe* itself through formal meetings, moments of informal co-operation, the circulation of information and the discussion of projects. This implies a collective "tension" towards consensus within the Service, which establishes effective relationships and, once again, reciprocity. The user is one of the poles in this dynamic and a decisive one: confronting his needs becomes the means for moving the institutional dynamics in a productive direction.

Operational autonomy also becomes a reality through processes which free operators from rigid shifts and duties. And while a collective work-style does not exclude regressive tendencies or conservative points of view based on objectification and corporative tendencies (which, in any case, must sooner or later manifest themselves), such elements must be assimilated and re-elaborated. "Common sense", alongside cognitive analyses referring to specific forms of knowledge, must also become dialectical. In this way, the Service-system will find its forms of "unstable equilibrium". When a proper tendency towards comprehensiveness is first proposed, the various professional roles will go into crisis, and will partially lose their clearly defined limits and overlap ("deskilling"; "everyone must be prepared to do everything"). On the other hand, this must be compatible with specific duties and responsibilities, just as the user's overall relationship with the Service – within which the most important therapeutic valencies take place – must not stand in opposition to a proper personalisation of the therapeutic relationship. This unified style must not be the result of directives imposed from "above", but must constitute itself through the synergies of individual, non-separate contributions.

We believe that the creation of a social life of the Service, in a continuous series of exchanges with the community, the neighbourhood, must be one of the Service's primary aims. This social life must be able to enhance the value of each moment in the relationship between user and operator and among the users themselves, even the most informal, and must include the participation of family members, visitors, etc..

There must exist the possibility of creating an atmosphere of affectivity and availability through the creation of zones of freedom (or protective niches) for all. A Service which does not select its users will see the most varied social figures – in terms of personal history, class, cultural attitudes and ways of relating – cross paths within its space. This will often lead to the formation of new relationships and personal ties of varying duration, and to forms of mutual support and involvement. The non-articulated,

the tacitly understood which can be perceived and gathered in the visibility of the suffering of others, in one's self-awareness in their relationships with others, in the possible multiplicity of expressions and behaviours – these too are very instructive therapeutic values.

All this does not occur “naturally” but is a result of a deinstitutionalisation style extended to professional roles and institutional relationships, and is especially due to specific efforts aimed at “opening up” the Service to all, to “never exclude”. We see the Service as a system of relationships which, precisely because it is open to the community, creates real exchanges.

One can often verify how the dramatic nature of crisis and the refusal of a relationship tends to dissolve within these apparently natural exchanges. However, it is necessary to create a communications continuum which utilises the expressive contribution of everyone involved, operators and users alike. The professional complicity with the user which is limited to the cognitive aspect is insufficient without affective participation, without that sharing which results from “living with” someone in the daily work of the Service.

Collective activities must be programmed in order to permit the active participation of users and occasions for wider exchange and discussion must be generally encouraged.

In this way, the Service functions as an enlarged and diffused therapeutic community which is open to the outside world, precarious and mobile in its parts, and which acts as a multiplier of relationships and encounters. Relationships originating in the Service often continue outside and beyond it, in the form of co-habitation, friendship or love. Someone who is alone and without a social network can thus find substitute relationships which are valid and non-institutionalised.

This also provides the seed for forms of active and collective participation which can then be channelled into discussion and mutual support groups (with parents, young people) and into diverse forms of more advanced and responsible involvement, as we shall now describe below.

### **New Service users and participatory networks.**

If such an organisation opens up possibilities for seeing needs, it also makes possible the dialectical co-existence of both healthy and ill elements. An important operational development is the need to propose initiatives with respect to the social needs which emerge. To do this, it is necessary to overcome the more institutionalised elements of the Service's time, and to identify and sometimes create other places which are less specific where this level of the demand can be shifted. To ensure that the response to this demand does not exhaust itself within the Service, there must be a constant “displacement” with respect to the Service as a place with a “psychiatric” connotation. Consistent with the analysis of illness as an institutional encrustation and prefabrication of the demand, the deconstruction, tapering off and deinstitutionalisation of illness must use multiple and differentiated resources and locations, locations which may vary from the district health centres to those of daily life. These resources and locations must constantly allude to entering a wider social reality, and in a way which is not merely superficial or ideological.

If the users tend to present themselves as a new collective subject, then this should occur in an expanded, social setting where there are “third parties” that can enter into the bi-polar institutional relationship. These too become collective subjects, and constitute an effective, participatory network originating with the Service.

1) WOMEN. Based on experiences being developed in psychiatry in certain areas of Italy (Ferrara and Naples, for example) and, in a more incisive way and from an earlier date, in other parts of the world (France, Germany, the USA and Central America, together with a theoretical analysis involve different professional roles (psychoanalysts,

psychotherapists, philosophers, teachers, etc.) which made it possible to interpret and analyse female distress and suffering in terms of gender difference, it was decided to initiate the therapeutic experience of the Women's Mental Health Centre.

In practice, this meant identifying groups of women with the most varied forms of suffering, in both psychopathological and behavioural terms, but who were prepared to confront their specific identity as women. In this way, numerous experiences and activities were begun which involved women outside of the Service who committed themselves to this work and provided intense support to individuals with problems.

**YOUNG USERS.** In the last few years, the participation of primary users and family members has been seen increasingly as a fundamental resource for building social support networks which are separate from the work of the community Services, and which develop that work while overcoming some of its limits. Enhancing the value of individuals and their abilities and resources when integrated into networks, appears as a fundamental factor in responding not only to the need for individual expression, emancipation and direct participation, but also the need for relationships and solidarity. A primary aim of the Service was thus the creation and active promotion of places and forms of encounter in which primary users could participate.

There is an ongoing effort to gradually transfer the Service's therapeutic atmosphere into other specific locations in the city, outside of the Service itself (a sort of "club"), in order to catalyse group processes. Here the pleasure of meeting and being together in various activities and on different social occasions merges with the effort to constantly strengthen the awareness that one is a citizen endowed with rights and to emphasise the need for self-representation. This reinforces reciprocal solidarity, creates new ways of being together, and widens and strengthens the users' social and support networks.

In this way, the Service wishes to stimulate more active forms of participation and, especially, of the self-promotion of mental health by overcoming conditions of social isolation, self-oriented demands upon the Service and its passive use by long-term users (especially young users), and with the aim of moving towards a reformulation of collective demands and needs.

This approach has also strengthened rehabilitation processes by improving social abilities through forms of activation and responsibility, and the involvement of users in socially useful activities based on their own capacity for initiative (activities which include providing services for others).

Today, the Mental Health Department has a number of programmes, and not only for free time but pre-training and cultural training in the widest possible sense, especially for young users. These programmes seek to promote the user's aware involvement; the stimulation of their ability for self-care and the awareness of the body as a medium for expression and communication; access to the community in an historical-social sense; using services; the comprehension of artistic, poetic and theatrical language; the aware participation in their own care and the management of their own health and sexuality; investigating their own social and gender identities.

**FAMILY MEMBERS.** The experiences and problems of the family members of seriously ill users, with the very heavy burden which results, has been dealt with through a psycho-educational and self-help approach aimed at developing more adequate coping strategies. More than two hundred families have participated in meetings (originally bimonthly and now weekly) over the last ten years. A dual approach was developed based on discussions with families and our own knowledge of the work carried out, and on the burden-related problems and the complex meanings which can be attached to illness: on the one hand, the Service works to develop strategies for dealing with illness as a reality which must be confronted (the psycho-educational level) and, on the other, it seeks to enhance the subjective participation of parents and family members. In short, our efforts were directed at promoting forms of participatory knowledge and an understanding of the situation.

This resulted in a transformation of the way in which the demand arrived at the Service: that is, there was a change in the representation of crisis, with all its corollary elements of alarm and tension. Family members' expectations also changed, and it was possible to move beyond a bi-polar demand, or "immediate change/cure" on the one hand, and "resignation/lack of expectations" on the other.

The programme for family members is currently structured in repeated quarterly modules that include informational conferences on illness and its management and treatment, and smaller group meetings with family members in each Mental Health Centre (talking about experiences, coping, and creating support networks). Last year, an autonomous family self-help agency was created with the support of the Mental Health Department.

## **Conclusions.**

The network of services in Trieste is still in continuous evolution because deinstitutionalisation must deal with the products of "deconstruction" which result from its actions and the needs which progressively emerge. This effort has been defined as the "invented institution" (Rotelli, 1988).

There has thus been a shift from a single place, or institution, where the inmates were "located", to the various user itineraries: social and existential, therapeutic (the programmes) and emancipatory, individual and collective (groups).

Today, community mental health practice cannot be limited to guaranteeing the preservation of the user's social fabric and the non-totalisation of psychiatry.

The mental health circuit tends to delineate a system of possible options which diversifies the response. By means of this system, the Service must be able to create effective and individualised therapeutic/rehabilitative "itineraries". "Shouldering the burden" brings the user into contact with a series of options which can be combined and modified. Choices must then be made, counter-proposals discussed and a therapeutic dialogue undertaken with the user.

The Mental Health Centre remains the "heart" and "mind" of the system, the planning centre which provides therapeutic continuity and the sense of a "project". The fact that it was conceived as a 24hr community service did not mean simply adding another function to an out-patient service (for example, providing beds within a community service or related structure; extending its hours or integrating it operationally with a night-time on-call service for the community). Instead, the intention was to enact a profound operational and philosophical transformation which placed the user's crisis at the centre of the Service's concerns. It thus sought to provide refuge, protection and recovery for weak individuals and, most of all, the possibility of multiplying the therapeutic offer and usable resources.

We can define such Services as areas for transition and mediation, though solidly rooted in the user's real, social experience; as places for mediation, recovery and rest but which provide a clear alternative to hospitalisation and its practices based on the user's social displacement, the uniform treatment of unique realities and the compression of personal differences within a system of rules and codifications. Instead, their operations are based on flexible responses and the involvement of multiple actors and resources.

When the process of transformation is carried out in this way, needs can be revealed, for the temporal continuum and rhythms of daily life and, within them, the links between "health" and "illness" (Basaglia, 1981) become truly central and can interact in very real ways. The individual appears in a mobile setting, where the relations which structure themselves tend to be free of rigid, institutional roles.

The Services, which in the '80's were modulated and organised with respect to the user's crises, have now become the crossroads and interchanges of the itineraries described above. This new outlook necessarily refers one to the problem of access to care and the possibility of social life. Today, the Services are completely committed to

this problem. Through their operations they daily address the issue of opportunity - and the real, concrete possibilities for opportunity – indispensable for achieving those full rights of citizenship which the law has guaranteed for weak individuals who, as mental sufferers, are also victims of social suffering and distress.

We can thus finally begin to talk about a “user-based Service” which is designed based on the user’s needs and rights, and not needs of the institution or the systemic demands for social control and regulation which the institution represents.

This process has resulted in the appearance of new forms of social subjectivity and in a dialogue with new actors and new needs (the families of users, women, volunteers and the productive forces present in the community) in order to realise that “utopia” of a participatory network of/with the Service.

The utopia of Social Enterprise, as an attempt to bridge the gap between the productive world and the non-productive and assisted world of the Services through co-operation and its “social surplus value”, suggests that the Service, as such, should eventually become a form of social enterprise. In this way, it would propose a new role for users as producers, and thus a new role for operators and the general public as links and instigators for itineraries in the outside world.

All these rehabilitation practices taken together, and used based on what we have called the “diffused” and “expanded” therapeutic community of the Service (but which must not be limited to this) has permitted maximising the use of individual human abilities and resources through access to levels of real participation in the Service’s activities and the construction of therapeutic programmes. This has resulted in the creation of a network of participation and social support which supports users in their context, thereby preventing forms of regression and institutionalisation and developing their social abilities and “healthy” valencies, emphasising the pedagogy of relationships, the construction of individual and group projects and the contribution of meaning which they bring to the Service.

Efforts must be made for obtaining more resources, and for improving the accessibility of such resources, understood as training processes for users in their relationship with their social network, in order to become that new figure which we can define as the “comprehensive Service user”.

The original, legal definition of rehabilitation should therefore be re-oriented with respect to the values and meanings upon which our work is founded. In order to free the ill individual from his special status connected with a his presumed “natural” incapacity and diversity it will therefore become inevitable, in the present situation, to confront the issue of his needs in terms of the effective realisation of his full rights of citizenship.