# *The Trieste mental health services: history, context, principles.* *

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1. *The situation of psychiatric assistance in Italy before 1960*.

With an asylum law dating from 1904 which made implementing compulsory hospitalisations a simple matter if a person was "a danger to himself or to others or created public scandal", psychiatric assistance in Italy after WWII can be briefly summarised as follows:  more than 100,000 persons were interned in public and private insane asylums, practices of physical restraint and shock therapies were widespread, there was a total suppression of civil rights, the inmates lived in subhuman conditions and there were very few trained professionals working in this sector.  The dominant cultural and institutional paradigm was one of custody and a prison-like segregation, with even Pinel's "*traitement moral*", or the asylum's presumed function of re-education, a forgotten aim.  The legal apparatus, for reasons which were both intrinsic to the law and to the procedures, in fact regulated, in synergy with the

psychiatric power, the social expulsion of the 'mad' and their internment. The scientific and cultural points of reference for the psychiatric discipline were still firmly anchored in a crude biologism of a positivist nature and, with the exception of a few praiseworthy pockets of interest for the anthro-phenomenological and psycho-dynamic approaches, there was not the least hint of the development of psychoanalysis and social psychology, even in the academic sector.

2. *Basaglia and the therapeutic community in Gorizia..*

In 1961, Franco Basaglia, a young Venetian psychiatrist educated at the University of Padua, with a keen interest in phenomenology (Husserl, Jaspers, Binswanger) became the director of the asylum in Gorizia. It became immediately apparent to him that the asylum was not a place of treatment for the inmates and that the very foundations of the psychiatric discipline (Kraepelin, Bleuler) did not provide any useful elements for setting into motion rehabilitative processes. Out of this realisation grew his conviction that the illness had to be placed 'between parentheses' and that it was necessary to try to understand the human reality of the inmate, which was hidden by diagnostic labelling and flattened and objectified by the institutional response. In this period, the progressive transformation of the Gorizia asylum into a therapeutic community – by giving decisional powers to the inmates and endowing the patients with subjectivity through groups, assemblies, parties, outings and stays outside of the asylum – represented not only a phenomenon of humanisation and rationalisation of the asylum similar to what Maxwell Jones had done in England, but also the growing conviction that the asylum itself, in any form whatsoever, even the most humane and permissive, was an institution that had to be done away with in order to fight the phenomenon of social exclusion and restore human and civil rights to the inmates. Basaglia and his team were definitely influenced by the vast movement for the development of civil rights in Italy (abortion, divorce, the various gains of the student's and worker's movements) and the international movement of the criticism of total institutions and psychiatry's very epistemological statute (Goffman, Laing, Foucault, Szasz, Castel). However, in the subsequent experience in Trieste, Basaglia soon went beyond these models, in order to establish a practice and a vision which was much more radical and consistent with the declared goals.

In 1972, the experience in Gorizia was ended due precisely to this declared intention of projecting the therapeutic community outside of the asylum (one of the authors of this paper, B. Norcio, was a direct witness of these events), which was considered risky and uncontrollable by the political-administrative power.

*3. The transformation of the Trieste psychiatric hospital and the projection towards the community*

It was in Trieste that, from August, 1971, the most important de-institutionalisation experience would take place, an experience which 7 years later would result in the Italian psychiatric reform, or Law 180. Despite disagreement, conflicts and resistance, this reform represents still today an advanced point of reference in Italy for lawmakers, technicians, local administrators, service users and operators, family members and society as a whole and, significantly, has even been cited as an important example of mental health care by the WHO.

Franco Basaglia acted based on his oft-stated conviction that the psychiatric hospital had absolutely no therapeutic value and that it, in fact, produced mental illness. The original models of reference, such as the therapeutic community in Gorizia and French sector psychiatry, were quickly superseded by the progressive opening up and transformation of the Trieste hospital. The ultimate goal of this process was the creation of a network of community services which would both substitute and provide an alternative to the hospital itself.

Here is a brief summary of the salient events in this process, which still continues today:

In August, 1971 there were 1182 inmates, with an annual turnover of about 2500 persons, 90% of whom were subjected to compulsory hospitalisation based on the 1904 law. The hospitalisation procedure had become completely automatic: after a brief examination by the doctor on duty in the general hospital emergency room, and the completion of some forms at the nearby police station, the patient, who was deemed 'a danger to himself and to others', was sent to the psychiatric hospital, and almost always in a state of physical restraint (bound).

In the early phases of the process it was still not possible to intervene on this procedure. What was done instead was to transform the compulsory hospitalisation into a voluntary one, utilising a little known from law from 1968.

There was thus an emphasis on voluntary hospitalisation and patients were offered the possibility of a new form of movement and of going outside of the asylum itself, together with the progressive improvement in the quality of life and treatment within its walls.

As regards the hospital-institution, during the first 4 years a great deal of attention was given to changing the internal areas (wards-bar-social places) and the systems of communication and exchange between the hierarchy and the *equipe*, and between the *equipe* and the patients. Daily meetings in the wards, periodic assemblies of all the patients and frequent staff meetings were held. Special attention was given to training nurses who were encouraged to abandon their traditional role as custodians. All of the doors in the wards were opened, and shock therapy and all forms of physical containment was eliminated. Outings into the city were encouraged, creating interest and attention, and sometimes alarm on the part of the general public. Relationships with the neighbourhood or community of origin were re-established, living groups and group residences were organised, first within the asylum and then in town. The persons who lived in this first residences were called 'guests' and this status, which was absolutely new and creative, meant that for these persons there was no longer any need for hospitalisation, but only for support. The structures which hosted these persons were personalised as if they were their homes, and detached from the hospital organisation.

The more able patients began to organise themselves and, in 1973, the first co-operative composed of 60 people was formed and contracted to clean the wards, kitchens and hospital grounds. These tasks which had been previously performed without payment as 'ergo-therapy', were now carried out by autonomous organisations which offered regular union contracts and a regular salary.

The creation of 'guests' and 'co-op members' and their official recognition through administrative resolutions, represented a real emancipation and acquisition of rights for the ex-inmates and demonstrated how it was the legal and administrative status of being 'ill' and not the disability connected with the illness which was the obstacle to any real process of rehabilitation.

Some other important actions: the city entered the asylum grounds - which had been previously surrounded by inviolable walls – for parties and concerts promoted with the collaboration of local cultural associations, with many students, young people and ordinary citizens participating. Various workshops for painting, sculpture, theatre and creative writing were established in the first ward had been emptied of its inmates. Marco Cavallo, the large blue horse made of wood and papier maché (and which was inspired by a real horse which used to draw a linen-wagon in the old asylum) became the symbol of the desire for freedom on the part of all the inmates and was carried in a procession through the streets of Trieste accompanied by more than 400 people. In the so-called 'maximum security' wards, everyone pitched in to remove the various

forms of grating, grillwork and wire-mesh. The symbols and means of internment were therefore removed, but in order to build alternatives.

Beginning in 1972, the internal organisation of the hospital was changed and the criteria based on the severity of behaviours – admission for the acute, agitated, calm, filthy, workers – was replaced by a criteria based on the area of origin within the city, which was divided into 5 zones. The staff was divided into 5 groups in turn, with each group operating in the zone of reference within the city and its corresponding area within the hospital. In this way, the work within the community was begun. Its aims in this period were releasing patients from the hospital and supporting them at home, 'shouldering the burden' for new cases and creating operational relationships with the institutions and inhabitants of that reference area.

At the beginning of 1975, there were 847 inmates, with a third already placed outside the hospital, either with their families, or in group residences and council housing.

The first neighbourhood 'precincts' were established between 1975 and 1977. These were structures which were originally set up to provide support to patients released from the psychiatric hospital, and to provide care for new patients. Functioning as day centres, they further reduced the population of the psychiatric hospital and the number and duration of hospitalisations, especially for cases of acute crisis.

In this period, while the network of community services was taking shape, the organisation of the psychiatric hospital was still fully operational. This was definitely the most delicate phase in the transformation process due to the fact that two different organisational systems were functioning contemporaneously, and because of the intensive investment of human and material resources. The resistance to change in the hospital structure was therefore becoming more acute, while the concern for the presence of psychiatric structures in the community was likewise becoming more vocal and evident. At this point, it was clear that there had to be a decisive change, and there was a maximum commitment aimed at terminating the functions of the psychiatric hospital and activating real, alternative responses through the network of community services.

In 1977, the number of inmates had been reduced to 132, of which 81 were voluntary, and there were 433 guests. The 24hr on-call psychiatric service in the emergency room of the general hospital was activated, with the aims of filtering the demand, finding solutions to crisis which were less rigid and administrative in nature, and opposing the automatic response of compulsory hospitalisation. The results were immediately apparent: due to the consultations by a small 'task force' in the emergency room (1 psychiatrist and 2 nurses) and the search for articulated and

differentiated solutions, the compulsory hospitalisations in the asylum declined significantly.

This experience would give rise to the Psychiatric Diagnosis and Treatment Service which, in the subsequent configuration of the Trieste Mental Health Department's community system, would maintain the function of a filter for the demand which arrived in the general hospital emergency room, as well as the function of providing consultations and a rapid referral to the system of Mental Health Centres. These Centres are present in each of the urban zones, with 8 beds and a canteen for lunch and dinner. They provide out-patient and home services, as well as overnight hospitality and a day-hospital.

Another activity guaranteed by the system of community services, and which prevents referrals to the forensic hospital, is the prison consultancy service. This service has the aim of providing care for prisoners with mental disturbances and seeks to encourage the application of alternative measures to detention.

In the system of community services the group residences were further developed in order to respond not only to the inmates released from the hospital, but also to those patients who needed to distance themselves from serious family conflicts. Rehabilitation and vocational training and placement activities also continued to be developed. A number of social co-ops were created which, within the context of much larger training projects supported also by the European Economic Community, aimed at creating work situations and enterprise and competing in the marketplace. Their activities were directed primarily at young people with psychiatric problems, or with problems of drug dependency or marginality.

The first phase of de-institutionalisation which involved the dismantling of the psychiatric institution and the creation of alternative community services can be seen as concluding with the 1980 provincial resolution which formally and legally decreed the cessation of the functions of the psychiatric hospital of Trieste.

Only two years earlier, spurred by the de-institutionalisation process in Trieste and in other cities in Italy (Arezzo, Perugia), the Italian parliament had passed Law 180 (the haste with which it was approved was much criticised, but was necessary to avoid the abrogative referendum of the 1904 law, proposed by the Radical Party, which would have left a legislative void).This law not only established new norms for compulsory treatments but, most importantly, prohibited the building of new psychiatric hospitals and ordered the dismantling of the existing ones. Franco Basaglia died in August, 1980.


*4.  Law 180 and de-institutionalisation as a model:  building the network of services.*

With the Law's approval, a completely new era began for all of Italian psychiatry   After being integrated in the same year with the general health reform, the law shifted the main emphasis of mental health work from the hospital to the community, separating, at least conceptually, treatment from the need for social control.

What is the content of this Law?

Above all, the Law says that medical evaluations and treatments are voluntary and that when  it is necessary to carry out a treatment against the will of the patient, this must be done in the full respect of the civil and political rights guaranteed by the Italian Constitution including, and to the extent possible, the free choice of the physician and the place of treatment.  In the case of a mental disorder, a compulsory medical treatment in a general hospital (Psychiatric Diagnostic and Treatment Unit) can be applied only when the disorder requires an urgent therapeutic intervention, the patient refuses the treatment, and there is no possibility for an alternative treatment in a community service.

However, every attempt must be made to obtain the consent of the person being subjected to the compulsory treatment, who can communicate with whomever they wish, have legal representation and appeal the decision to apply a compulsory treatment.

The first phase of treatment is limited to a very short period of time (one week, though this period may be extended) with the evident aim of avoiding inertia and forcing all of the actors involved - professionals, patient, family members, friends and administrative and legal protection agencies – to use maximum speed in limiting this exceptional situation in which a person's freedom is being suppressed.

An interlocking system of controls and counter-checking guarantees is imposed which attempts to reduce as much as possible any abuses.  The provision must be approved by the mayor, as a representative of the community, instead of a magistrate, thereby underlining that this is a measure for the safeguarding of someone's health and not a security measure against a threat to public order and safety.

Finally, by emphasising the priority of the community over the psychiatric hospital, the law establishes that no new hospitals can be built and that the existing ones must be gradually closed. It also gives a mandate to the Regions to construct – through its own administrative and legislative acts as well as through the allocation of specific funds and resources – new community services which shall be completely alternative to the hospital. In the meantime, they were obligated to utilise small hospitalisation units of not more than 15 beds, ie. the Psychiatric Diagnosis and Treatment Units.

However, the five existing forensic hospitals for the confinement of those who have committed criminal acts but who have been judged as not legally accountable (though still a threat to society), are not included in the Law. This remains a legal and institutional contradiction in need of innovative solutions, some of which have already been debated and proposed and are ready to be considered by Parliament. In Trieste, at least, since the start of de-institutionalisation to the present day, a special effort has always been made to block referrals to the Forensic Hospitals and find some alternative measures instead.

It should be emphasised that the Italian model of de-institutionalisation, in its legislative guidelines and as a coherent and effective system of practices, is not merely a policy of pure and simple de-hospitalisation in order to cut costs or apply some pseudo-emancipatory ideology by releasing patients into the community without any points of reference or any form of support. Instead, it is a theoretical-practical process which takes a highly critical approach with respect to the legislative, administrative and scientific apparatuses which supported the paradigm of illness as danger and, based on this perspective, totalised the entire existence of the individual by producing a total institution to maintain that individual and keep them separated from society. "De-institutionalisation is a critical-practical process which reorients institutions and services, energies and knowledge, strategies and interventions, from an artificial object which is the illness (understood as a diagnostic label) towards the patient's suffering-existence and his or her relationship with the social body as a whole" (Rotelli). In the asylum, the patient is deprived of power and freedom, civil and political rights, social relations and exchanges and, because he is identified exclusively in terms of the illness, is the object of pure control and violence. Instead, with de-institutionalisation, the ill person is at the centre of the process, in all of his uniqueness and complexity, so that it becomes possible for the patient to become an active participant, a 'protagonist' in his own cure and rehabilitation.

In order to achieve this, it is not enough to close the psychiatric hospital and release patients into the community in accordance with some facile ideology which, in fact, only fills the ranks of the homeless. Instead, it is essential to build community service networks which promote itineraries for health and the exercise of individual and group rights. Without delegating to others (though with all possible forms of synergy and collaboration), these Services must deal with the problems and difficulties of such itineraries within the social space of the community and thus outside of the 'reassuring' walls of the asylum. It is in the community that one must find a balance between the principle of autonomy, ie. the respect of the patients' free will and capacity for self-determination (their 'subjectivity') and the principle of beneficiality, understood as the

operators' duty to promote each patient's well-being, and safeguarding their life and health.

As a recent document (November, 2000) of the Italian National Committee of Bio-ethics states:  "The safeguarding of the patient's subjectivity takes on, in the contemporary medical-ethical framework,  the value of a paradigm given that it is the indispensable condition for the construction and development of freedom.   Such freedom should be understood essentially as a process of liberation which originates with a fundamental ethical requirement of the person… this concept of freedom is closely connected to the principle of autonomy, which refers to an absolute respect for the person.  In order to avoid dangerous misunderstandings, it should be specified that safeguarding the patient's subjectivity does not mean believing that he is free, but instead helping him to become free".

The challenge for services which are created through a process of de-institutionalisation consists precisely in this responsibility for processes of liberation.

5.  *The implementation and development of psychiatric reform in Italy.*

Today, more than twenty years after the reform law and with a social, cultural and political situation which has changed profoundly with respect to 1978, we can affirm that the complex events which marked the application of this law in Italy and the development of services alternative to the psychiatric hospital have in no way changed the meaning and value of the model and aims of de-institutionalisation, as we have defined it.

With respect to the resistance and difficulties that the implementation of the law had to deal with, we need only recall that in the first 15 years there were 19 different bills proposed to change the reform or in some way legislate a return to the past.  Many of the Regions which were required to build new services and shut down the existing hospitals within the individual provinces by means of autonomous legislation and funding, did little or nothing.   During this period, the professionals, and in particular psychiatrists, were divided into two groups:  those who were in favour of applying the reform and practising de-institutionalisation and the others, the majority,  who explicitly boycotted the law by refusing to act, encouraged the uncontrolled release of patients, who were then abandoned to themselves, refused to intervene when requested by family members, and vacillated between the neo-custodial practices of the Psychiatric Diagnosis and Treatment Units in the general hospitals and selective psycho-therapeutic practices which had little effect upon the more serious cases.  The various governments which succeeded one another with a certain regularity in Italy, were

unable to find the strength necessary for imposing a plan of implementation for the law, with clear indications and a definite timetable. Significantly, the family-member associations which were formed in order to obtain more efficient therapeutic, assistance and rehabilitation responses for their loved ones, were almost all in favour of real actions and results, and thus the creation of effective services, and had little interest in taking sides in some ideological debate.

In this context, which was definitely problematic and, at times, even chaotic, even the judiciary (which was frequently called upon due to incidents, the omission of interventions, and to provide interpretations of the rights and obligations of the various parties involved) appeared disoriented and confused. The radicalisation of the conflict between the law's supporters and opponents at times created a situation which was purely 'political' and crudely reductive, such that those who were in favour of the law were classified as 'left-wing' and those who opposed it as 'right-wing', which was certainly true in the latter case, but not always in the former. Indeed, in Regions administered by the left, de-institutionalisation was often not encouraged, while Regions governed by the political right permitted the development and growth of local experiences which successfully carried forward this process.

Ultimately, the truly decisive factors for the application of the law were the real practices and the commitment of operators, who worked alongside the patients, families and ordinary citizens. It was this which has permitted a real 'shouldering of the burden' and assumption of responsibility for dealing with the problems created by the de-institutionalisation law. It was based on these real experiences, their growth in the community and the daily work in the area of providing treatment and shouldering the burden for seriously ill patients, their rehabilitation and the construction of the rights of citizenship, that the law demonstrated its value as a profound cultural and institutional transformation which went well beyond mere slogans or shifts in the political situation.

Trieste was thus not alone in this great civil struggle for mental health. By continuing to grow and consolidate its model, it showed how certain courses of action were not only possible, but necessary and applicable to all the other situations in Italy. Over the years, its visibility and credibility has continued to increase at both the national and international level, with a multiplication of relationships and exchanges with many other local experiences in northern and southern Italy, Europe and many countries around the world.

Providing a practical and verifiable model of how it is possible to manage psychiatric assistance and promote mental health without asylums through the implementation of a law which takes this as its main principle, remains the chief strength for the group in Trieste and all the other Italian localities that work in a similar way.

From 1990 to the present, many changes have taken place in Italian health policy in general, and in psychiatric assistance in particular. There was the semi-privatisation of the public health services.  There was great change in the positions of the majority of psychiatrists and universities, with the official acceptance and promotion of the reform. Most importantly, the principles of the reform law have been progressively accepted by all concerned, and all the Regions of Italy have finally legislated and financed the closure of the remaining psychiatric hospitals and the development of alternative community and hospital-based services. In a five year period, the government issued two national project-goals programmes for mental health (the second of these was for the period 1998-2000) which took as its principles and operational model for many of its functions the statutes of the Mental Health Department which, based on the Triestine model, the Friuli-Venezia Giulia Region has adopted since 1980.

The number of social co-operatives, as a tool for rehabilitation and assistance, has grown enormously in all of Italy. This movement also began in Trieste nearly three decades ago, in 1973.

And finally, there has been a growing awareness and consensus among all those involved in mental health practices – patients, family members, professionals, politicians, administrators and ordinary citizens – concerning the ethical-social dimension of mental health and the need for care and rehabilitation to take place within a context which respects human dignity and the rights of citizenship.

6.  *The Trieste Mental Health Department in 2000:  organisation and principles.*

As indicated above, the organisational configuration of the Mental Health Department (MHD) already began to take form in Trieste in 1980 with the regional law approved for that purpose.  The aims and goals of the Department were clearly synthesised in three points:

1)  The MHD was the structure designated  for the practices of prevention, diagnosis, treatment and rehabilitation in the area of psychiatry and for the organisation of the interventions aimed at safeguarding the mental health of the general public;

2)  The MHD must work towards removing any form of discrimination, stigmatisation or exclusion of persons with a mental disorder or forms of mental distress and must actively participate in promoting the full rights of such persons.

3)  The MHD must guarantee that the mental health services constitute a single and coherent organisational system.

After Basglia's death, the new director of the MHD, Franco Rotelli, was given the task of developing and completing a community services network which would be completely alternative to the psychiatric hospital. The goals were those which had already been declared: extending and increasing the response to the mental health needs of the local population; reinforcing the networks with the other private and public services present in the community; increasing the offer of services and projects, multiplying encounters with the local institutions and creating solidarity networks.

With the help of artists, teachers and diverse professionals, various expressive, rehabilitative and training workshops were created, and there was a growing attention dedicated to job training and job placement with the establishment of new social co-operatives for the service users and the young people of Trieste. The rehabilitation and social integration of the guests of the former asylum continued in autonomous living spaces or in group homes within the city. The grounds of the former hospital were gradually restored and returned to the city for other uses (university faculties and other educational facilities, various health services and hostels for foreigners and visitors). The roads and grounds of the ex-asylum grounds are now used by the local residents like any other area in the city.

Today, for a population of about 240,000 (with a demographic decline of nearly 30% in 30 years), and with an overall cost of about ITL 27 billion (or about 4.5% of the total public health expenditures which, when the values are adjusted, corresponds to about half of what it used to cost to maintain the old asylum), the MHD has at its disposition the following network of services of structures:

- **4 24hr Mental Health Centres,** with each centre serving a catchment area of about 60,000 people and integrated with their respective Public Health Districts. Each Centre has, on average, a staff made up of 4 psychiatrists, one psychologist, 25 nurses, two social workers, with 8 beds for day and overnight hospitality. It provides the following services: *hospitality*, which can vary from one night to several weeks (10 days on average), in order to respond to crisis, provide protection and guardianship, offer help and a form of distancing for both the patient and their family (with the use, if necessary, of compulsory medical treatments); *daytime hospitality or day-hospital*, to encourage participation in recreational, therapeutic, orientation, training or informational group activities, as well as to help relieve the family burden, follow psycho-pharmacological therapies and just to be with friends; *home visits*, either programmed or on request, for handling crisis situations in the home, verifying and learning about the actual living conditions of the patient and his family and possible accompaniment services; *individual therapy*,

consisting in programmed meetings with a psycho-therapeutic value which focus on personal histories, the dynamics of conflict and the prospects for real change; *family therapy*, focusing on the power relationships, the affective dynamics, communication, the objective conditions of burden; *group therapy*, for dealing with common problems, organising free time, widening the social network (this work is also done with family members); *rehabilitation and prevention*, consisting in direct and indirect interventions for the activation of social and professional abilities (often in conjunction with vocational training and job placement programmes), promotion of tools and itineraries useful for gaining access to information, culture, sports and recreational activities; *social-welfare support*, meaning support programmes for patients in need and their families, including economic support (benefits for social integration, vocational training grants and grants for other rehabilitative activities), also indirectly by directing or accompanying the patient to agencies or institutions in order to obtain the same forms of assistance (public housing institutes, tribunals, pension offices, unemployment office); these programmes can also involve the management and administration of financial resources or property in agreement with the patient; and finally, *consultancy*, which is offered to the various wards of the general hospital, generally not in crisis or emergency situations (see the Psychiatric Diagnostic and Treatment Service), both for patients who are already known and under care or for new patients.

- **the Psychiatric Diagnosis and Treatment Service,** located in the general hospital. The reform law provides for 15 beds, but the service in Trieste only has 8. Currently, the regular staff is composed of 2 psychiatrists and 16 nurses, but due to the network modality used by the MHC's and the Service's function as a filter in the hospital emergency room, all of the doctors of the DMH in effect participate in this system and are on-call nights and holidays, on a rotation basis. All of the other MHC professional figures (nurses, psychologists, social workers, educators, etc.) are also involved when they begin to 'shoulder the burden' for the patients from their respective areas. The Service's functions include: providing psychiatric emergency treatments, urgent consultancy services in the hospital wards, filtering referrals to the community services, integrating responses for patients in a crisis situation who are in prison or who are referred by the legal system. Despite the fact that his is an 'emergency' Service, its methods and atmosphere are low-key: the door is always open and no one is physically restrained. Whenever there is a situation which requires dealing with particularly aggressive behaviour, police or security can be quickly summoned. The Service has the highest possible level of

permeability and family members, friends and acquaintances, or anyone else who wants to see the patient and is accepted by him will be admitted at any hour of the day or night.

Being situated in the hospital also makes it possible to obtain rapid internal, surgical or specialised consultations, as well as laboratory and instrumental exams. This is the reason why patients from the MHC's are sometimes given hospitality in the Service.

Of the 2000 contacts by slightly more than 1000 patients in the year 2000, about one third resolved their problem quickly and were sent home after a consultation with the advice to go see their family doctor, another third were advised to request a consultation at their local MHC and the remaining third, which had more serious forms of mental suffering, were quickly put into direct contact with operators from the MHC's, and generally on the same day.

- **Rehabilitation and Residence Service**, which co-ordinates the structures intended specifically for training, rehabilitation and social integration. The *residential structures* are 'homes' in which MHC users live together, and where the cohabitation is determined and aided by the Centres themselves. They are divided into residences for social integration for guests who are supported in their daily lives if the need arises and therapeutic-rehabilitative residences for guests with more significant disorders and with a greater degree of disability. The purpose of these structures, which are partially or totally protected, is to improve the self-care and attention for one's environment, give more freedom in daily life and improve social and family contacts for those who live in them. In 2000, there were about 140 guests living in a total of 29 structures. The *Day Centres* are workshops which carry out and develop educational, training, social skilling, scholastic and recreational activities. Here, through small group activities, the users acquire abilities, qualifications and relational capacities. In order to achieve these aims, the participation of volunteers, art teachers, actors, teachers, occupational therapists and ordinary citizens is encouraged. Among the various activities, the literacy courses for adults with serious disabilities or because they have relapsed into illiteracy and the courses for attaining an O level (junior high) diplomas, which are carried out in conjunction with the Ministry of Education, have proven especially useful.

*Social Co-operatives* – These enterprises are aimed not at making profits but at job placement for disadvantaged persons and they work in close contact with the MHC's. There are now 9 co-ops, involved in the most diversified activities: from

the traditional sector of cleaning and gardening, to managing a hotel and bar, to running a radio station, a video production centre and computer services. They have more than 200 worker-members, more than 50% of which are disadvantaged, come from 'high risk' areas or are service users in vocational training programmes. In fact, the co-ops are specifically designed to provide various forms of vocational training (and thus users with vocational training grants can be sent there by the Services) and to perform their business activities with aims and criteria which have been identified as 'social enterprise'. Social enterprise is a philosophy and a project for activating resources and synergies and bringing about a cultural transformation with respect to the traditional separation between the productive world and the world of social reproduction. In other words, their challenge is to find the optimum balance between competing in the marketplace with quality goods and services and permitting socially weak individuals to empower themselves and acquire a sense of social worth, and thus a balance between production and social reproduction, between competition - which is typical of the work- and marketplace - and solidarity, assistance and comprehension, which pertain to a social welfare tradition.

- **Volunteer, family and self-help associations** work closely with the MHD. These were formed at different times and for different purposes – the need to widen the social network for users, for gender differences, self-help for families and patients, the work of promoting and developing knowledge in the area of mental distress and disorder and the multiplication of possible responses – but with the common features of working in synergy with the aims and activities of the DMH, thereby avoiding sterile confrontation and conflict. The result of this synergy is the possibility of increasing the power of representation and intervention in the social area. This approach doubtless derives directly from the very specific and particular experience of de-institutionalisation in Trieste and elsewhere in Italy which has always seen the multiplication of social actors – together with the involvement of non-medical professionals – as the main key to its success.

From 1995 to the present, a period in which community health in Trieste was further developed through the creation of the Health Districts and the various Departments (including a special department for substance abuse), the DMH developed additional projects for integration with the Districts and with the City of Trieste's social services, projects which were all aimed at improving prevention.

These projects included a specific **suicide prevention** programme, with the creation of a mixed group made up of the MHD, a 'help-line' company and the City of Trieste. This programme has the function of not only monitoring the phenomenon in question, but also providing a help-line so persons in distress can talk to trained counsellors, and creating the possibility of intervening in all visible risk situations. Other programmes include a **support programme** for **people who live alone** (primarily the **elderly**); a programme of close collaboration with **general practitioners**, identified as 'health tutors', which aims at monitoring and intervening with respect to the general health conditions of psychiatric patients who are much more likely to have their health problems overlooked or ignored than the rest of the population, as well as other work and intervention groups for the **elderly, children and adolescents, persons with handicaps**, consultancy services, or 'listening points' for **immigrants, eating disorders** and **women's health**.

A **Service charter** has been drawn up which affirms and recognises the **rights** (especially for psychiatric patients) of free expression, the respect of sexual orientation, the right to communicate with whomever one desires, being informed on treatments, the right to association and the right to choose an operator of reference of the same gender. Also worthy of emphasis is the right to not be subject to actions which violate one's physical integrity and dignity, especially means of physical restraint, and the right to have one basic needs met and to be supported in the search for forms of emancipation.

Table of the structures and functions of the Mental Health Department, 2000.

| | NAME | N° |
|---|---|---|
| STRUCTURE | 24hr Mental Health Centre | 4 |
| | 12 hr Mental Health Centre | 1 |
| | Psychiatric Service in General Hosp. | 1 |
| | Day-centres and workshops | 3 |
| | Residences | 29 |
| | Social co-ops | 9 |
| | Associations affiliated with MHD | 3 |

| FUNCTIONS | PROGRAMMES |
|---|---|
| Overnight hospitality | User training and involvement |
| Hospitality/Day hospital | In/formation for families |
| Out-patient and home visits | Involving G.P. (health tutor) |
| Psycho-social support/networking | Prison consultancy |
| Psycho-social re/habilitation | Suicide prevention |
| Residences | Assistance for elderly persons living along |
| Semi-residential | Aiding associations |
| Vocational training | Literacy courses |
| Job placement | Creative/recreational activities |
| Socialising/leisure time | Promoting self-help |
| | Closer relationships with Health Districts |
| | Closer relationships with hospitals |
| | Relationships with city cultural agencies |
| | Gender differences and mental health |

7. *Some additional observations on the organisation and evaluation methods of the DMH.*

The organisational framework of the Services presented above, appear as being very articulated and differentiated.

Over time, we have become convinced that in order to respond adequately to the public's mental health needs we must move 'towards' those needs as they actually present themselves, without filters or predetermined selectivity (e.g. based on the diagnosis).  Based on this premise, the administrative-bureaucratic plan was designed to facilitate the reception of the demand, reducing the formalities for access to the Service to a minimum (direct access, no waiting lists, exemption from deductibles on the services provided).

The organisation of this complex organism is based on the need for a **differentiation** of structures and functions together with the need to find ways and means for their **integration** and co-ordination.

This is both the most delicate and most interesting aspect of the current organisational model.  The multiplicity of structures available and the equally large and varied number of functions performed carry with them the risk of dispersion and the loss of organisational coherence.

Seeking to maintain a high level of integration among the different components of the network of services has always been a major concern, at all levels.  From the very start of the effort to transform the institution, great importance was given to the occasions of collective work and discussion/reflection on the problems to be dealt with, whether involving only a single case, or something which impacted on the entire Mental Health Department.

Since then, operator meetings have remained a fundamental element in the overall organisation of the MHD, and are recognised and participated in by all concerned. Currently, there exist numerous occasions for meeting and developing operational strategies collectively:

- the MHC meeting, held daily in every operational unit at the changing of shifts, which constitutes the most important operational  moment; it is a time for reflection, but also for taking decisions together;
- the weekly department meeting which is open to all MHD operators, for the purposes of discussing the general issues regarding the mental health service;
- the staff meeting for co-ordinating the chief operators.

In addition to group discussions and reflection, work groups which have been created for specific project-goals regarding particular aspects of the service have also become a part of the MHD's organisational make-up.

The general purpose of all these meetings is to guarantee a high level of internal communication, exchange and participation in the operations, methods and goals of the Mental Health Service.

With respect to evaluation, operators in the mental health sector know well the difficulties involved in combining daily work with the ability to observe and therefore evaluate the quality of the services being provided. While the problem of evaluation in psychiatry, especially in terms of outcomes, is still far from being resolved, it is equally evident that the need to elaborate effective ways of analysing the work done cannot be avoided. The need to offer sufficient guarantees for the quality of the services being offered has been recognised in Trieste for many years now and though Italy provides few points of reference in this area, an attempt has been made to organise a stable system of observation and monitoring for the activities carried out, and with the aim of ensuring the maximum attention to the assessment of quality.

Despite the difficulty in registering and codifying the wide range of services provided, for some years now a stable informational system has been in effect capable of monitoring the most significant indicators of the MHD's various activities. Together with this system, a commission has been created for the continuous improvement of quality, which co-ordinates and implements the individual projects for the improvement of quality initiated each year.

It is important to remember that in the field of mental health the variables involved – cognitive, affective, relational and material – are many and of such a nature as to render any correlation between actions and their effects very difficult, and that the psycho-social nature of the interventions are themselves difficult to reproduce by means of operational protocols. The efforts made to date thus do not constitute a definitive solution to the problem of evaluating the effectiveness of a mental health intervention; however, they can be considered as a progressive approach to an optimal treatment. Finally, it should be remembered that, in terms of organisation, the need to subject the services to evaluation, which creates a constant commitment on the part of the operators, takes on major importance in directing and orienting the professional comportment of operators towards a proper 'reading' and interpretation of user needs, based on the constant perception of the discrepancy which exists between what is done and what *could be done*.

8. *Final considerations*

Twenty-five years after beginning the process for the deconstruction of the psychiatric institution and psychiatry as a discipline, we are able to indicate the essential points for putting into practice a collective action for community mental health and can identify the 'vectors' of transformation capable of orienting in a coherent manner the processes of institutional transformation.

These elements have been synthesised by Franco Rotelli in an article entitled '8 + 8 principles for a community psychiatric strategy' which define the field of action for practices of psychiatric transformation.

These 8 (+8) points are as follows:

**1)** the fundamental shift of the perspective of the intervention from **the hospital to the community**;

2) shifting the focus from **the illness only to the person and social abilities** (empowerment);

3) the transition **from individual to collection action** with respect to patients and their context:  this is a collective work strategy which implies, at the very least, the following conditions:

3.1) the use of **multi-disciplinary** abilities and competencies;

3.2) enhancing the patient's resources and capacities for **self-help**;

3.3) enhancing the **family's** self-help resources;

3.4**) educating the general public** in order to eliminate the mystification of the concept of danger and the irrational prejudices which surround the mentally ill, with a special emphasis on cultural initiatives which can change the social view of illness;

3.5) increasing and enhancing greatly the **collaboration of non-professionals**;

3.6) **rethinking the value, in terms of their effectiveness, of solely biological therapies as well as the exclusive use of orthodox psychotherapies**.  These tools (techniques) can obviously be fully integrated into the therapeutic activities of Community Mental Health, but it is equally obvious the serious defect deriving from the transposition of practices and techniques which are only tools (useful as they may be) into conceptual models for the general interpretation of illness.  In this way, due to inertia or totally irresponsible decisions, very specific practices are taken inappropriately to provide the conceptual basis for the organisation of the services.  Something else entirely is the appropriate (and attentive and critically aware) use of these techniques and therapies within the context of Community Mental Health

strategies.  This is the essential requirement for the usefulness of these therapeutic tools and approaches, a usefulness which is partial given that they are only components of a multiplicity of responses which must operate on many different levels at the same time;

3.7) Enhancing the **forms of active solidarity** which are provided by the more aware, attentive and positively inclined **social organisations**, as well as by local institutions which are more open to social issues and problems;

3.8) The **open door** (that is, the daily and continuous effort not to delegate to the door and/or physical restraint the commitment to confrontation and exchange, at times extremely difficult and stressful, with the reasons and motives of the other person.

4) The **community dimension of collective action**.  The construction of a theoretical and organisational frame of reference which consists of a specific territory, a defined population, and the progression assumption of **responsibility** with respect to that population, and not to a specific institution and, thus, the organisation of services which refer to that territory and that population;

5) The **practical-affective dimension** of the actions taken.  It is impossible to over-emphasise the therapeutic value which develops when there is an affective dimension to community work which is rich in content and reciprocity.  One can never insist enough on the value of collective actions capable of modifying in real terms, and even in very small ways, a patient's real living conditions.

To these we can add strategies of community action:

6) The effort to create a body of formal rights and draw up legal and administrative norms which **defend patients' rights**;

7) The implementation of **social policies** directed at the personal reproduction of weak individuals and the primary importance which should be attributed to resolving problems related to housing, work, job training, socialisation, the quality of life and the empowerment of psychiatric patients;

8) The effort to draw up **important agreements with various local administrations** in order to produce organisational changes in line with the strategies which have been indicated.

We are convinced that the integrated community model for mental health services can be established anywhere, both in organisational and economic terms, if two basic requirements are met:  that there exists the political-institutional will to create and

sustain such a model and that there is the awareness that maintaining the Psychiatric Hospital in any form is neither feasible or practicable, certainly in the long term.

Today, in Italy, it appears that these conditions which were set forth in the 1978 law are slowly being realised. A great deal still remains to be done: the remaining forensic hospitals must be closed, care must be taken that the hospital services do not become new, 'mini-asylums', the model of 'strong' community services must become more diffused and, most of all, great care must be taken that new structures of containment and ghettos, with different names but still based on the culture of exclusion and paradigm of internment are not allowed to be created again.

The Triestine experience began with the struggle against this culture and these practices, which historically were present in psychiatry (but not only), and this is the struggle which we intend to continue and carry forward.

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[i] Psychiatrists
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