Responding to Crisis
Strategies and Intentionality in Community Psychiatric Intervention[*]

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1. Introduction: Crisis and the Psychiatric Circuit

It is difficult to give an unambiguous definition of crisis in psychiatry. Whatever the frame of reference, any definition must ultimately take account of the existing psychiatric organization in that area and at a given historical moment.

There exists, in fact, a threshold-value relative to these two contingencies, beyond which the emotional, psychological, inter-personal and social problems, and the daily occurrences of life assume the characteristics of crisis and become of specific psychiatric concern.

Usually, a person in crisis enters the psychiatric circuit, in which the psychiatric hospital represents – and represented in Italy before Law 180 – the last resort.

In accordance with the systems of recognition, the «threshold value» of entry into the psychiatric circuit will be redefined in each given case, as a threshold of suffering, of anxiety, of social danger, of poverty, of the pressures of family and work relationships, of the diversity in behaviour, of intolerance, of the level of violence inherent within a particular social context.

Crisis intervention centres (originated in English-speaking countries in the 1950's) generally use quick, early methods of intervention aimed at an immediate solution of the problem outside of the psychiatric circuit and, in particular, seek to reduce the number of admissions to the psychiatric hospital.

We believe, however, that these therapeutic interventions are short-term and do not utilize methods which offer comprehensive care to the patient in crisis. Consequently, they are unprepared to deal with possible failures and, in fact, generally have recourse to more «serious» institutions, leading finally to the psychiatric hospital, in this way sustaining and confirming the centrality of the psychiatric hospital itself. The persistence of the psychiatric hospital as a catch-all for the human refuse of these operational models guarantees its practical and ideological sterility, namely, the possibility of utilizing impermeable and selective technical schema acritically in order to identify specificity, classify behaviour, homogenize what are discrete and heterogenous problems; and

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therefore always providing a preformatted response, seeking to read the conditions of the crisis within defined and manageable parameters.

Analogously, the community services which operate in the shadow of the psychiatric hospital tend towards "specialized" interventions of rehabilitation and resocialization: supervised workshops, social centres for leisure time, programs for re-entry into the workforce, vocational training schools, solutions to housing problems, group-houses, economic aid.

All these interventions are generally offered in a fragmented and uncoordinated manner. And even though these services have contributed (and contribute now) to a decrease in the population within the psychiatric hospital, they still make no provision for failures, are proportioned to meet specific needs, and are selective and impermeable one to another.

The psychiatric circuit, assured of the psychiatric hospital, has developed into a highly complex, specialist working model. But its model of cultural references has not changed at all. All the practices developed by it, continue to use separate lines on intervention and to fragment the response to a person's needs into various therapies.

Any course of therapy designed this way with an infinite number of options is usually difficult to negotiate for those who really need it.

Paradoxically, the choice of highly diversified services is often disproportionate to the opportunities available for using them.

The inflexibility in access, in referral and in the other phases of the circuit not only fails to resolve a crisis but often provokes one.

Because the system cannot recognize the patient as a complex entity, is simplistic and reductive. It is always the patient's crisis which is seen, never the crisis of a system which cannot cope with an overwhelming number of requirements.

The moment when a person in crisis is given attention can be identified as the point of greatest simplification. The individual has already gradually simplified and reduced the complexity of his suffering to symptoms, so that they might be noticed. The service, a model of simplification, responds by equipping itself to perceive only those symptoms.

In this work we intend to record our experience and attempt to show how conditions of crisis actually correspond to very complex life situations and how resources and methods aimed at the protection of such situations should, therefore, be complex too.

To create the conditions whereby a crisis may express the overall needs which life presents, it is necessary to start from a specific symptom, though this represents an over-simplification.

In fact, the concept of crisis in psychiatry arises out of an invention, correct at a theoretical level, to reassess mental illness by investigating suffering in the individual's life. The individual must be viewed as a "biological unit" as well as a "member of a system" and even as a "social subject".

In the sense, the concept of crisis has been an attempt to apply a single methodology. It does not produce uniformity but specifically seeks out the individual nature of the problems presented by the patient. It tends to avoid treatment or approaches based on the medical model.

By examining the patient's individual history, the symptom too can be identified as a significant factor, part of a reality which has now become intelligible.

In our experience, the many occasions for contact between the service and the individual (in the places where s/he lives, has a network of relationships and material problems) can be used to reconstruct a person's life history. This helps to locate the crisis within a series of relationships which in turn render it comprehensible (but do not explain it!). Finally, it helps to salvage the valuable connection between health, life values and the crisis. An individual's life history is regarded both as the reconstruction of his/her social, institutional and emotional experience and also as the mending of the fracture in his/her experience caused by the crisis in question.

In our case, the phasing out of the psychiatric hospital, and the establishment of mental health centres[1] – the final phase of the work of deinstitutionalization – have created a practical and conceptual problem. It is the problem of understanding complexity which exists wherever there is a demand for psychiatry and wherever there is a crisis.

The specific mental health centre (CSM) in which we work operates in a small district. It is equipped to deal with all requests which elsewhere would be identified as psychiatric, and to eliminate any administrative filters. It favours means of access which are informal and varied. It does not attempt either to select or to refer patients elsewhere.

The mental health service, therefore, assumes a central position within the defined area. It becomes a unique point of observation in which interactive observation can be developed. It will reflect everything which the community may produce in terms of pathology, deprivation, conflict and social disorder: it will be protracted constantly and steadily over time; it will follow personal

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[1] Currently, the psychiatric network in Trieste (population 280.000)is comprised of 7 mental health centres operating in an equal number of zones within the city, each with a population of around 40.000. the psychiatric hospital in Trieste is no longer functional, at the present time accommodating slightly more than 200 persons of which about 40 are bedridden and the remaining 160 residents living in small familial groups with nursing assistance limited to daytime hours. In March of 1980, the Psychiatric Service for Diagnosis and Care (SPDC) was established within the General Hospital (and which, for our purposes, is better defined as the Psychiatric Emergency Service or SEP), provided with 8 beds and performing the functions of psychiatric first aid and "clearinghouse". Patients referred to the reception ward of the General Hospital are then entrusted, after initial treatment, to the local centre to which they appertain, the SPDC only hosting patients during night-time hours and in which case the patients are referred to local centres the following day. Distributed within the city are 21 living groups comprising around 130 persons. In addition, there are three work co-operative societies aimed at eventual employment (patients and young people who are "marginal" and not yet under psychiatric treatment) involved in cleaning, building, gardening and within the various workshops for theatre, music, painting, carpentry, sewing, video, graphics and leisure time. The co-operative societies, firstly conceived as alternatives to "work-therapy" in the asylum, today involve around 200 workers and are guaranteed by payments through national service contracts. Since 1980, the Mental Health Service has also intervened within the prison in Trieste with the aim of aiding and following up inmates who have a request, whether already under psychiatric treatment or new, and for whom there are therapeutic programs aimed at social reintegration and alternative measures to detention. The primary objective being to prevent a legal referral to the forensic psychiatric hospital. (It will be recalled that Trieste has no private clinics and that the University Psychiatric Clinics has 40 beds).
From the full application of Law 180 until 1986, the number of compulsory treatments has totalled 31 (3.7 annually), of which 70% of cases were treated through the C.S.M. and the remaining 30% through the SEP. The number of patients resident in Trieste who have been sent to forensic psychiatric hospitals has declined from 10 in 1979 to 1 in 1985. At the present time, there are only three citizens of Trieste interned in forensic psychiatric hospitals in all of Italy.
The actual organization of the service has been in continual development during the last 15 year swhen the work of transformation of the Psychiatric Hospital of Trieste first began in 1972, at which time it had 1200 patients. All medical and paramedical personnel, the primary workers within the hospital walls, have progressively transferred since 1975 into the sorrounding district, re-training themselves and contributing to the organizational structure as it exists today.
[For additional references cf. Gallio, Giannichedda (1982); Gallio, Giannichedda, De Leonardis, Mauri (1983); Gaglio, Mezzina (1983); Dell'Acqua, Cogliati (1984); Rotelli, De Leonardis, Mauri (1986)].

histories and the evolution of that district and its population. The service will therefore be able to adapt its response accordingly.

The service is capable of identifying and entering into contact with and working out of the conflictual network of relationships which constitute a crisis. These might otherwise have been hidden, trivialized or deprived of sense by the process of simplification which usually takes place whenever the working model is based on the centrality of the psychiatric hospital.

Obviously, we do not wish to propose solely a more profound reading at the cognitive and interpretative levels of the crisis. The most difficult problem is the need for an organizational model of the service which will encourage appropriate responses to complex situations as and when they emerge.

2. Intervention, Social Control, Emancipation

The psychiatric demand is certainly complex and it is necessary to understand all its constitutional elements: the means or individuals by and through whom the demand is made, the course followed before arriving at the service, the preceding institutional experience.

The service must be capable of reading the trail or course that leads from a crisis which is silent and incapable of being heard, to behaviour that is transgressive or alarming and a sign of suffering, resulting finally in the social systems of emergency being set into motion. In addition, it must organize different modalities of contact, curtail the periods of latency of the crisis and provide precocious intervention, developing an operational method which connects the crisis to all the other psychiatric demands which express themselves in forms other than that of emergency. In this way, the crisis finds itself in a unified practice of prevention, care and rehabilitation.

In fact, the efficient response to crisis cannot be separated from the work of prevention (secondary) which bases itself on the correct practice of "assuming full responsibility" for *all* the elements in play. In such a way, the service must extend its potential of relations to cover the entire gamut of expressions of the existence that suffers as well as the entirety of community demands.

We maintain that to await the patient within the service and rigidify the protocol of intervention unavoidably delegates a recourse to the traumatic mechanism of compulsory treatment or, at the least, to police intervention or admissions to acute units.

Just as concerns the demand for «social control» (always connected with the demand for intervention), the presence of the service and the immediate coping with the situation of crisis, redimensions the feared «danger of the mentally ill», enabling the subject to develop other modalities of expression and the social context to comprehend, through the mediation of the service, his requirements. The conflict that manifests itself in crisis can, in this way, be assumed as a stimulus to transformation, to the growth of the situation in its complexity and context and not simply contained or hidden.

It is evident that the conflict, and within it the crisis, implies a power struggle in which the patient, to the extent that he is identified as such, often suffers a net loss. This also occurs when the patient seems to maintain a manipulatory control exercised through the symptom.

In any case, the conflict occurs within a predicament or trap that crystallizes the patient and others and impedes the possibility of emancipation for all.

If the service proposes, among its objectives, the search for just such a possibility of emancipation, it will try to furnish itself, as is our case, with the tools and resources capable of encouraging the growth and autonomy of the patient, and of defending and increasing his contractuality. In this way, support for the autonomy and power of the patient cannot exhaust itself in sterile forms of guarantees and a passive defense of the patient's rights as an individual, but presupposes an itinerary of transformations for all. The problem of social control, from this perspective, redefines itself as the necessity for transformations of a situation that is «blocked», and in which the role of the service is to promote diverse means of the social reproduction of the subjects in question, in particular the user and his/her immediate relations. The historical oppositions in psychiatry between repression and emancipation, between control and care, can in this way find a path of issue as difficult and «elevated» as it is productive and rich.

3.   Crisis Intervention and Contact

In the description which follows, we refer exclusively to one of the 7 Mental Health Centres that constitute the new organized network of psychiatric services in Trieste, the Mental Health Centre of Barcola[2] (see fig. 2). The quantitative data reported here refer to new users (first contact with the service) in the triennial period 83/85 (377 individuals total).

Out of this group of patients, we have recognized as "situations of crisis" those which responded to at least 3 of the following 5 arbitrarily designated parameters:

1.   Severe and acute psychiatric symptoms;
2.   Serious breaks in family and/or social relations;
3.   Refusal of psychiatric care (medication, hospitalization, therapeutic programs). Claiming not to have need but accepting the contact;
4.   Obstinate refusal of the psychiatric contact itself;
5.   Alarming situation within the family and/or social context.

These parameters, in our opinion, define (in community care) those situations sufficiently severe or alarming to have resulted, before deinstitutionalization and the reform law, in compulsory admission to a psychiatric hospital and the declaration of being "a danger to himself and others".

Excluded from this group are all situations of crisis related to patients already in contact.

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[2]   The C.S.M. of Barcola began to function in 1975 with a staff of 10 nurses and 2 doctors and occupied itself initially and primarily with the discharge of in-patients from the Psychiatric Hospital of Trieste. The cathment area covers 2 district with a total population of 45.000 and a surface area of 10.1 sq. km. The use of the service has increased and diversified progressively, in step with the decreasing functions of the psychiatric Hospital and the growth of credibility and penetration of the centre into the district.
At the same time, there has been an increase in the number and an improved structuring of the medical and paramedical personnel assigned to the C.S.M., making available, with the gradual closure of the Psychiatric Hospital, further personnel who had previously worked inside.
At the present time, the staff consists of: 19 nurses working at the centre; 3 nurses assigned to a living group of 12 persons; 2 nurses assigned to 4 small living groups with a total of 12 persons; 2 social workers; 3 psychiatrists.
This results in a worker-population ratio in our view optimal: one nurse for approximately every 2.000 persons, one doctor for approximately every 15.000 persons and 1 social worker for approximately 20.000 persons.
The Centre is open 24 hours a day, every day, including Sundays. During the night, 2 nurses are on duty to assist patients who make use of the overnight hospitality while future referrals and emergencies are handled by the above mentioned SEP. During the day, medical and paramedical personnel are always present from 8 a.m. to 8 p.m. [For additional references see Cogliati, Dell'Acqua (1982); Gallio, Giannichedda, De Leonardis, Mauri (1983), Pastore, Debernardi, Piccione (1983); Dell'Acqua, Cogliati (1984)].

Using this methodology, we have isolated 108 individuals out of 377 new users that requested, during the three years in question, an intervention in a "situation of crisis".[3]

In addition to the quantitative data contained in note (3), it is here important to underline the fact that the means by which acute patients come into contact with the psychiatric circuit has also been significantly transformed in Trieste as the result of fifteen years' work. From a time when the only means of access way by (compulsory) hospitalization to the admission ward of the psychiatric hospital (finally closed in 1980), the ways of reaching the district health service have become gradually more direct (74% of all crisis situations in 1985), reflecting a growing awareness and use of the district service on the part of the community and the network of health, welfare and law enforcement services.

In fact, if in 1983 36.6% of crisis situations passed through the SEP (Psychiatric Emergency Service at the General Hospital, see note 1), that percentage fell to 26% in 1985.

In the three years, the individuals who have come to the Mental Health Centre through the SEP in a state of crisis represent of 33.3% of the group under consideration and of these, 12 of 36 arrived at the SEP on their initiative, alone or accompanied by the family. In the remaining 24 cases, the arrival at the SEP was the result of intervention by an emergency service (Red Cross, Police) at the request of a third party.

One third of the demand continues to arrive at the SEP, not because it is a preferred "channel" for acute crisis within the organization of services, but because a part of the psychiatric demand is still referred to the General Hospital as a matter of course by the emergency services and sometimes by the families or friends of the person in crisis as well. In addition, during the night (8 p.m. – 8 a.m.), the mental health centres have no psychiatrists on duty whereas, at the SEP, one is present around the clock. In any case, an encounter with the SEP has the sole value of a first visit and involves a primary level of decision, to treat the individual or not, and the intervention therefore resolves itself in a very short span of time. In fact, only 13 of 108, 12% of the group in question, remained overnight in this service during the three-year period.

Of the remaining 72 cases that came in direct contact with the CSM (Mental Health Centre), 66.7% of the total, the greater part, 32 out of 72 or 44.4%, were on the initiative of family or friends: about a quarter were referred by general or military hospitals (20 out of 72 or 27.7%, and of which the grater part, 16 out of 20, were attempted suicides that were first admitted into emergency care wards); 11 out of 72 (15.2%) were referred by neighbours; 7 out of 72 (9.6%) by doctors or other health and social-welfare institutions of the region; and 2.7% were referred from prison or by the police (2 cases). Of this group, 12 out of 72 cases (16.6%) arrived at the centre on their own initiative or accompanied by the family.

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[3] The group in question was 55.6% women; 48.8% of the total were 55 and older. The high percentage of over 55 corresponds to the general demographic characteristics of the area (around 20% of the population is 65 or older). The order of types of symptomatology (with reference to broad diagnostic groups) was follows: *acute psychotic* crisis (acute schizophrenic episodes, paranoid states and reaction, etc.) represented 31.4% of the cases; *suicide attempts* (with various pathologies but which have been regrouped on the basis of the principal motivations for a request for intervention)21.3%; *states of confusion/disorientation* of a *psycho-organic nature* (senile dementia, presenile etc.) 12.9%; *maniac states* 10.1%; disturbed behaviour due to alcoholism, addiction (states of agitation, dysphoria, hallucinations etc.) 9.2%; crises of *severe depression* (major depression, serious depressive reactions etc.) 7.4%; *state of acute anxiety* (neurotic, situational, reactive etc.) 7.4%
We would like to point out that it is already working a three-year follow-up; it is going to form the subject of a further study.

Increasingly, it is the workers at the centre who are called upon in the first instance when a request for treatment is made.

Contact with the patient at the first signs of crisis can differ in time and mode. If the patient does not present himself at the centre, the workers soon take on an active role in establishing contact. Whenever possible, the places of contact will be those where the patient spends his time naturally (his home, the bar, the workplace, etc.) and the intermediaries will be people important to his environment.

The service is prepared to be as flexible as possible in this regard. It does not operate according to pre-determined methods of treatment nor with specialist teams.

More often than not, availability itself, actually being "on the spot" prevents traumatic impacts: just the worker's presence givens immediate reassurance to relatives, neighbours and the environment. Being "on the spot" can defuse a crisis which is causing anguish to the patient and to whoever is closest to him. Sometimes it is not possible to defuse a situation. This occurs most often in cases where the patient is alone, with very few resources and very few relationships with the outside world. Such a person will obstinately refuse contact and isolate himself still further. The service, then, has to increase its "banal strategies" of approach: telephone calls, messages under the door, involvement of others such as friends, the priest, the local policeman or the plumber; or even attempts to make contact in several places. These attempts give determined proof of attention and help, and in this way the service tries to engage in a reciprocal relationship which, even if it is conflictual, constructs a real frame of reference around the individual towards which he can direct his actions and behaviour.

At other times, a sort of escalation is identified and continued refusal induces the service to pay greater attention to the user's contractual power and to his requests: thus the service is increasingly obliged to show its flexibility.

In the end, the escalation can conclude with "physical" contact with the patient which can be both dramatic and "strong".

Opening the door (rarely forcing: only 5 out of 72 cases, 6.9% requested the collaboration, at the first contact, of emergency services, which, in our case, signifies police and fire Dpt.) is also a symbol for the breaking of the psychotic circle, the entry of real faces and the end of the nightmare.

The application of these diverse pressures and tensions inevitably overcomes the most obstinate barriers. Even when the patient persists in seeing the worker or the service as an intruder, these moments of offering, listening and practical help (in the home or in the centre) manage to break down the diffidence and reluctance and create a worker-patient relationships, and the therapeutic program can commence.

4. Assuming Full Responsibility
The expressed intention to resume not solely those of the "crisis as an emergency" but the diverse moments and forms of a "suffering existence", characterizes the central aspect of the practice of our service in its " real time development". We call it "assuming full responsibility" (and not simply "taking care of" or "looking after).

Taking responsibility refers primarily to the *service's active responsibility for mental health* of the whole of its catchment area. Not only in situations of crisis, but also in the comprehensive relationships (in respect to the moments and forms of the existence that suffers) this creates a new modality of institutional relations that bases itself precisely on the full assumption of responsibility. In other words, the mental health centre must undertake the function of being an *active reference point* relative to situations on conflict, misery and disorder.

The risk of "social control", as an inheritance from the old mental hospital system, has been reworked in the district by the workers who are actually present. By relinquishing traditional systems of control and reducing to a minimum any delay between the time when a problem emerges and the time when contact is made, the daily practice of "being there" has produced in our experience a real penetration by the service into the district and has created a useful awareness on the part of the community concerning its functions.

This practice strengthens the link between the service and the district, makes it more direct and facilitates conditions for reciprocal relationships. Actively criticizing the distance which is assumed to be intrinsic to the professional role and which is often used lovely as a means of control of the object of its work (which, in our case, remains always a subject), makes explicit the intention of drawing closer to the patient, of involving the service in his destiny, precisely in those areas of responsibility for mental health previously described.

Assuming responsibility means, therefore, to assume the demand at all *social levels* connected with a state of suffering. The user's social context is not bureaucratically separated out into various areas of competence. The individual is accompanied and supported by the service throughout the network of social institutions (court, prison, hospital, welfare office, school, child services, housing department, job office, family counselling, nursing homes, benefit offices, etc.) which have to be activated by the service in response to the user's needs.

The assumption of the demand as a total request, of immediate patient needs as well as the delegated request for control, constrains the service (and the workers) to observe in broad and unpreformatted manner the conditions of the patient and his relationships and a requires a direct interaction with the same. *The assumption of responsibility means overcoming in a concrete way the opposition in-patient/out-patient* treatment typical of the medical model.

Recourse to hospitalization in psychiatry is generally determined, in situations of crisis, by a decision technical (degree of severity) as well as administrative-legal ("social and personal danger"). Hospitalization removes the individual from his context and subordinates him to institutional regimens founded upon a medical approach, to clinical observation that limits itself to symptomatology and excludes the complex of the patient's life.

Taking responsibility does not mean that a specific place where this happens must be established. That place can be the mental health centre, other institutional agencies (public hospital, prison, etc.) but, mainly, it would be the user's environment where he lives or tries to live his social life.

Even when treatment for crisis takes places in the mental health centre through the various means of hospitality which are available 24 hours a day, users continue their relationships with their environments. Relatives are friends can visit at any time. Often the client will be accompanied back home soon after periods of great domestic tension in order to collect clothes and personal belongings, to see relations, to "verify" the conditions and, at times, the "existence" of his home with a worker.

All this is designed to guarantee and communicate to the individual that arrival at the centre does not mean breaking with life's continuity. The client may also go outside the centre, alone or accompanied by a worker, volunteer, relative or another patient so that s/he can see that s/he has not lost autonomy or freedom.

In this way, the centre acquires a symbolic connotation as a place for relationships, and not as a limitation or segregation, more or less temporary.

The multiplicity of these relations of faith and trust not only represent additional means of resolving the conflict, the refusal of relations with the service, but are therapeutic in themselves. They are opportunities to rebuild the identity of the patient and/or repair the relationships that had broken down before the crisis (and which are often worsened by hospitalization). At the same time, they continue to communicate the availability of the service to the patient, the alliance, in a way that does not wish to confirm a labelling or further loss of power, as occurs in the case of hospitalization "on its own". As well as demonstrating the desire to aid and care, they also have the intention of "shifting" the demand, in the sense of a redefinition of the problem in terms of "usefulness" that are perceptible to the patient as well (as will be seen further on in our description of the therapeutic program).

Sometimes, a user will leave the centre, reaffirming his refusal and breaking the relationships which have been established. In this case, the workers are obliged to find the user, re-establish contact, and review his/her demands at the new contractual level which the breaking of the relationship has proposed.

The flexible management structure as well as the ways of taking responsibility described above do not mean that the service fails to recognize the need to protect individuals who behave alarmingly and who risk being exposed to sanctions from the apparatus of social control (e.g. ordinary or psychiatric prison); or for which their free circulation within their social contexts, due to the levels of non-autonomy and destructiveness they express, might further compromise their contractuality, burning the terrain of relationships and straining the levels of tolerance. In all of these situations the centre assumes responsibility for keeping control and providing safeguards for patients. But the nature of these methods (ban on leaving the centre, limitation of movement or contact with relations, sedation) is personalized by the figure of the worker who follows, assists and "accompanies" the patient.

Physical control does not exist at the centre, as objectified in structures of restraint (locked doors, isolation rooms, means of physical restraint), and therefore never appears as a "given" but as a concrete choice upon which the possibility of contracting still remains, and must be explained and motivated in order to create a further awareness in the patient. However, in every instance where there is recourse to a more rigid and directive management of the patient and which contains the risk of closing the relationship with him, and thus of objectification and manipulation, the contractual negotiations continue and can reverse this management into an activity in which he himself participates.

Hospitality at the centre forms part of a series of gestures and events which precede, accompany and follow it. It is always part of a course of treatment and never a response to crisis "in itself". It is used as a tool to explore and redefine the therapeutic relationship which is "insufficient", creating a greater reciprocal awareness and the possibility for new departures in the therapeutic project. By directing particular attention to the management of hospitality within the service, more human energy and institutional resources can be brought into play, so that the attention of the whole centre

can be focused on the patient. In this way, the therapeutic values that are inherent in the structure of the centre itself can best be confirmed.

This extreme peculiarity in the experience of hospitality at the centre, in the experiences of the patients as well as relatives, represents an operation of dismantling, both practical and symbolic, of the "asylum". Through the transparency of institutional acts and their legibility, it is possible to determine transformations in the demand that, in our experience, is no longer one of total delegation and internment.

5. Organized Listening

A patient who arrives at the centre is never subjected to a psychiatric consultation aimed at diagnosis and founded on a unidirectional and objectifying sense on the part of the professional. Usually, an attempt is made to establish a relationship in which each party gradually gets to know the other, and in which several workers and sometimes other patients are involved.

The new patient is given time to orientate himself within the space of the centre, to perceive and comprehend the attention shown to him/her, and to begin to circulate and act within that space.

An atmosphere where people are readily available encourages many exchanges and interactions between patients, professionals and other members of the staff (cooks, cleaners, linen keeper and co-operative users trained for this kind of work), other patients and volunteer workers. Often collective discussions and meetings take place spontaneously and these are encouraged by the professionals. Several patients may be involved in these discussions and are thus instigated to confront one another and to arrive at a mutual awareness of the problems and levels of communication that exist in themselves and in others.

Even the daily lunch-time meetings during which the professionals exchange information and thoughts do not exclude patients. In fact, they are encouraged to participate, to listen and comment on the topics being discussed. Sometimes a patient is inspired to speak out concerning what s/he considers to be his/her "own problem". On these occasions, patients are listened to and given collective recognition and thus the "problem" comes to the attention of the group without there being an attempt at interpretative mediation. Often, and particularly in situations of crisis, these informal moments prove to be most significant and useful for the patient.

The more formalized occasions for listening – i.e. a defined place and time for conversation between professionals and individual patients – are never characterized by the conditions of psychotherapy according to some predetermined model, but occur within and are a part of diversified moments of listening and awareness. In general, these conversation are aimed at facilitating the expression (or, rather, the verbalization) of the needs which underlie the demand, to encourage comparisons between the real life situation of the patient and the contradictions in respect to that, to analyse what occurred with the onset of illness and to relate that condition to and in the context of the continuity of his life history, to reconnect it with "normal" life through a shared examination of his personal history and the social and experiential course followed preceding the illness. The reconstruction of these links and mediations will, in itself, reduce anxiety and reassure the patient. At this point, it becomes possible to identify the actual problems that can be dealt with at that time and to formulate a practical program that takes account, on the one hand, of the patient's capabilities and their possible growth and, on the other, of the resources already available or that can be made available through greater efforts within the organization.

Both the formal and the much more numerous informal occasions for listening tend to provide avenues of awareness of what it means to be among others, of listening to one's own needs as well as those of others, of self-control and of listening self-centredness and self-aggrandisement. The relationship built in this way also answers the need for "education", generally posed by the patient and his relations, in the sense of understanding and analysing together the meaning of the illness-experience and of deciding on further courses and scopes of action in the process of reconstruction and emancipation.

It is evident that none of this occurs "naturally", but presupposes a task that is both finalized and intentional, that produces the exchange and circulation of knowledge and information.

Such a task is continent upon and intimately concerned with the awareness of the worker that he moves within a service and that all the therapeutic values are realized within and dependent upon the overall relation between it and the user. Analogously, the personalization of the relation between a single operator and an individual patient, which is certainly pursued, must be recycled into the "ensemble" as an added richness and possibility of verification.

6. The "Time Value"

When hospitalized, whether in a psychiatric hospital or in the psychiatric unit of a general hospital, the patient lives his time entirely within the time and rythms of the institution that contains him.

Thus time, the fundamental axis of experience, including crisis, is the first value taken from him. Hospitalization separates "sick time" from "normal or healthy time", defines the duration of illness and organizes, according to its own norms, the day-to-day life of the patient. In this way, hospitalization modulates or determines the cadences of the cadences of the times and rythms of crisis.

The time of a patient in crisis can, however, express itself autonomously in respect to time as imposed by an intitution to the extent that it, the mental health centre, is a place that is permeable and non-separate, and where any ordering of time by imposition/constraint/uniformity is difficult and unwanted.

The use of time, both for patients and workers, can become a fundamental tactical factor in the project of intervention.

The time passed in contact with the service can be filled with acts, presences and presentations useful to the person in crisis (or recognized as such by that person) and the patient's time can be joined to the time of the intervention in ways that are often ambiguous and conflictual.

As concerns the workers, the discussion on the daily program during the "assumption of responsibility", is underpinned by the intention not to interrupt or upset the daily routine of the patient, who must "go on living" despite the crisis. The organized and administered time of the service must be linked to the patient's time by means of discussion on his own proposals and initiatives. This respect for the patient's time becomes thus an additional factor reinforcing and preserving his own potential as a "subject" and not as an "object" which is dominated and institutionalized.

In short, time can represent a value which the patient can reappropriate, preserving his ties with his context and daily life, but at the same time intersecting with the flexible "duration" of the service program and, possibly, commensurate with his levels of need.

7. The Art of Relating

Inside such a centre, rendered liveable twenty-four hours a day and "passable" for the patients, every moment of contact with others contains the possibility of an encounter and, therefore, of interpersonal relationships, of resocialization, of aggregation, and also of conflict.

A primary network of temporary ties can be reconstructed around the patient, particular ties of involvement and affection with workers and other patients. Forms of reciprocal help can arise where one patient becomes a point of reference and support to another with greater difficulties.

These relationships, though conceived within the centre, often continue and endure outside it and thus new relations of cohabitation, economic integration, tolerance, solidarity and love develop.

The coexistence of diverse forms of distress can create a scenario that permits a multiplicity of expressions and behaviours, and within which each can find their own place. This coexistence in the centre of acute and chronic patients, of young and old, of different degrees and forms of pathology and of different social classes, demonstrates not only its possibility but its usefulness; for the confrontation among diverse subjects, for the criticism of the imaginary fear of madness, for the growth of awareness in each patient of the problems of others. This "diversity and difference" induces in the workers a comprehensive vision of mental health problems and problems in the service, avoiding sterile specializations and permitting reciprocal enrichment of diverse practices: i.e. intervention in crisis and rehabilitation, attention to daily needs and attitudes towards listening, "medical" practice and "social" practice.

Even particular areas within the centre, generally considered to be unconnected with the therapeutic activity, such as the laundry, the office of the social workers and particularly the kitchen, can in this way cease to be separate. Workers trained in specific functions, valuable as subjects, are also capable of occasioning therapeutically valuable interchanges that base themselves on attention to the patient and disponibility.

Outside the centre, the locations which serve to enrich the psychiatric service (workshop for painting, theatre, sewing, ceramics, graphics, music and sailing) are additional means of reconstructing relationships and the capacity for relationships.

In contexts which are different from the centre and, therefore, less specific and in which roles delineate themselves less clearly and strongly, and in which the reference is simply the group as such, the patient experiments with other models of expression and finds a collective recognition, but also has the possibility of crisis containment and recomposition.

8. The Therapeutic offer: the Social Reproduction in the Crisis

The *situation* of the patient manifests itself progressively to the attention of the service in all of its complexity, as an ensemble of subjectivity, social relations and the material conditions of life.

The first contacts and instances of verification focus on the real life of the patient and how he meets his basic needs: where does he live and sleep, what dos he, what are his income and expenses, who does he see and who is around him, where does he work. These discussions encourage the placing

of these elements of real life in a historical perspective, make the patient and his family more aware, clarify the contradictions and conflicts at work.

The connections which develop during this process of knowing the patient (already therapeutic in themselves) lead, in a natural progression with practical actions, to the response which we define as the *"therapeutic offer"* of the service.

The mental health centre has provided itself with an ever increasing quantity of resources, such that it can attempt to respond to a diversity of situations and needs. By resources we mean what is at the disposal of the service in terms of material aid, tools, services, locations and occasions for meeting and socializing.

The richness of the service is the result of choices made as a direct consequence of the work of deinstitutionalization, oriented, in our case, toward developing moments of social security and legal protection and support for patients within the area.

The combining of the use of these resources with actions more readily defineable as "medical" constitutes, in each given case, the therapeutic program. As concerns the use of psycho-active drugs, we recognize in them no intrinsic therapeutic value, but, rather, a relative utility for the opening of potential relationships, for the reduction of individual anxiety and, from time to time, for the temporary control of behaviour.

Besides activating other services and institutions, that we have already mentioned, resources or services are directly provided by the C.S.M. The principal of these concerns the living situation (restoration, maintenance and cleaning, the search for other housing solutions), money, income (cash subsidies, use of the safe in centre, daily money management on a temporary basis, action taken in defense and protection of property), personal hygiene (laundry, personal cleanliness, hairdresser, linens), work possibilities (assignment to a co-operative society, chores at the centre, work grants), free time (workshop in theatre, painting, music, graphics, sewing, ceramics, gymnastic and boating, day trips, holidays, parties, cinema, shows).

These and other activities presuppose *standing by the patient.* Visiting relatives, re-establishing relations with neighbours, providing for his domestic and daily needs, accompanying him to shopping, buying clothes, medical visits, preparing documents, depositing money, verifying work or simply "going out" together; all of these are operations which tend to conserve and simulate a relationship with the external world and promote a more confidential and informal relation with the worker outside the centre.

The practical actions of the service are therefore nor merely episodic instances of support but are integrated towards broader ends.

Responding to need means, first and foremost, furnishing the material instruments of "social reproduction" and improving the quality of life, gradually promoting profound and continual transformation in the operation and philosophy of the service, increasing the contractuality of the patient and confirming him within the context. And if, in addition, the time of response to the demand decreases to a point where it is almost adequate or equal to the urgency of the demand as proposed by the patient in crisis, then that becomes an additional, important factor in the resolution of the crisis itself.

In our view, the peculiar *therapeutic* quality of an intervention conceived in this manner is evident, though it is often interpreted reductively as "charity and sympathy". The work that develops around

the crisis as "response to need", continually offers workers (nurses, attendants, social workers, doctors) a real level of possible relation; permits the immediate translation of technical terms into concrete problems; inhibits the tendency in psychiatry to expel from the intervention as dross, anything that has to do with the material condition of life; encourages concrete exchange between the diverse subjects in action; promotes "standing by" the patient.

What is equally evident to us, is the relation between a change in the empiric reality and a change in subjectivity that is verifiable not at a level, as "grand" as it is impossible, of existential transformations, but, rather, at the level of the much smaller changes that the individual action of the workers produce within the daily life of the patients. These actions and gestures constitute the mediations in the relation of trust between user and service.

Everything said thus far, therefore, concerns not only the material needs but the alternatives, transitory, or not, proposed to the patient in crisis. These alternatives can develop only within the continuous discussion with the patient on the ways in which he himself lives this change in reality, of how he confronts and modifies himself accordingly. We do not pretend to effect a reading or gloss of the needs which underlie the psychiatric demand, but, rather, to furnish responses, in the awareness that these have a circumscribed value in time relative to the appearance of the needs as a contingent fact, and which permit the patient to reinforce himself and make a further progress towards the reacquisition of social identity and a contractual power.

In the process of reinforcing contractuality described, and in the contemporaneous subjectification of the patient, there exists, on the part of the service, an attention to the continual reformulation of the demand.

The problems of the patient are constantly redefined; in the relation with the service the patient can progressively bring to fruition new levels of need and consciously seize the same. He can progress from the inarticulated language of the crisis to a capacity for understanding and expressing his own needs and expectations of life, towards which the service must orientate and organize itself. (This is the task of "deinstitutionalization" as we understand it; and it represents the final and most difficult stage of this process, because it alludes to psychiatry as the "concealment" of human problems).

9. The Crisis of the Service: Breaking Down and Reconstructing the Institutional Equilibrium

It is impossible to realize this "work upon the subject" if there is not a complementary and contemporaneous process of "work upon the service". The problem is to develop and optimize the therapeutic potential that the service possesses, in as far as it is a cumulative sum of resources and subjectivity.

The personalized therapeutic program materializes itself precisely in the working out of the conflicts between the service organization and the concrete problems posed by the patients (the "needs"). What we define as flexibility, or the ability to determine an adequate operative response for each given case, cannot be determined simply through the organization of labour or the "disposition of the service". Flexibility is possible through the continuous effort to work in a collective manner, in which everyone has the possibility of making their contribution. The circulation of information, the discussion of problems and possible solutions, the ample provision made for confrontation through the daily staff meetings and the continual exchanges between workers during the working shift, can generate greater interest and understanding and a group involvement in the problems at hand.

Workers must be given the possibility to express themselves within the group and work with patients at different levels. The process of deinstitutionalization created autonomous areas of decision-making and operation for each professional; the hierarchy has also been severely affected and thus the separation of roles and tasks, permitting a division of labour as horizontal as possible, yet preserving the value of each single professional contribution. In this way, self regulations on hours and interventions outside of rigid work scheduling, on projects already finalized, has been promoted. The "new deal" created now includes more subjects: doctors-nurses-workers-patients, permitting, in an informal way, the expression of the creativity and abilities of each, and according to the singularity of their own culture, language and character. Collective discussion on the choices regarding the treatment of each patient offers each worker the possibility of influencing the group, and not anarchically but through the constant collective verification of how that work is done and what results are obtained.

This arrangement, which is a historical product of the process of deinstitutonalization as concerns the organization of labour, *is not a given* but a condition of possibility. The service remains always an institutional space and as such reproduces continually regressive aspects of institutionalization, in the user's relations to the service as well as in the worker's relation to his work.

The productivity of such a system (producing health, subjectivity, social reproduction) requires continuous investment and search for new resources as well as the capacity to resist declines in productivity, failures and "disorder". A system such as this is in a constant state of "disequilibrium" and always in danger of fragmentation or collapse. The diverse and often contradictory requirements of the various professionals, always in delicate balance between the corporate defense of their profession and the easing of its restrictions, between a satisfaction of subjective needs and a full response to the needs of the service, forms the central focus, both critical and conflictual, through which the operative strategy is worked out.

The daily routine, in particular, must ensure continuity but not so as to become the merely repetitive execution of gestures and instructions.

Reference to medical and psychological models in the daily activity constitutes only a part of the ensemble of possible theories and practices into which they are integrated but never considered as absolutes. This confrontation with the codes, tools and language of psychiatry, via their attempt at definition/non-definition and confirmation/non-confirmation, can become a fertile provocation for the conception and growth of autonomous languages and of different understandings.

The rich store of practical knowledge and immediacy of the primary workers, their proximity (often in class and language) to the problems of the patients, as well as the resistance, prejudices and general opposition that exist, constitute the necessary and contradictory richness out of which a unified practice can be constructed, an operative style which, without selection or expulsion, tends to characterize the therapy of the service.

It is necessary to return to a correct dialectic the oppositions which the practice brings to the fore, often with violent ruptures, such as liberate/oppress, abandon/control, deal with every problem/practice psychiatry.

And always there is the possibility that distance between worker and patient will reproduce itself, through inattention (non-listening), objectification, prevarication, or the passive induction to chronicity.

The capacity of the service to constantly engage itself in these critical junctures and nodes, to live them as "crises" in themselves, permits it, in a process that is certainly not linear and often disorderly and at the cost of conflicts that are often severe, and the risk of "burning out" its workers, to reproduce and perpetuate itself and confront the risk of its own institutional nature.

The emergence, from time to time, of new and singular methods of confronting crisis is thus fruit of a daily struggle for the modification of neoinstitutional mechanisms in the functioning of the service. As respects the life of the service (and thus of general projects, new ides and stimuli etc.), only a comprehensive view can create the conditions in which adequate therapeutic programs are formulated and realized.

In order to create a just balance between identification with the patient and distancing, between an emotional involvement and a collective diffusion of the anxiety of the relation, between a personal investment on the part of the worker and the support of a wider group, it is necessary that close attention also be given to the subjectivities of the individual workers.

In this case, and in many others, the centre must be able to be an *"expanded therapeutic community"*, with undefineable limits, that has its own internal life, but that also extends itself into and is open to "the outside world"; in short, the sum of the myriad of personal and institutional paths that intersect within its space, both real and symbolic.

10. Conclusions

Instead of aiming towards a resolution of the conflict within the personal context (familial or microsocial), attempting to arrive at a rapid normalization of the subject in what is the most common strategy of "crisis intervention", the response to crisis by the district service is more inclined to connecting and placing the patient in contact with a system of relations and human and material resources. Once the patient has entered into it, the crisis evolves in a collective context. The patient must be enabled to pass through the crisis preserving his historical and existential continuity. The structure which is activated by the assumption of responsibility is orientated towards guaranteeing that the patient's ties with his environment be maintained, the individuation of the nexuses between the crisis and his life history, the reconstruction and redefinition of relationships with significant persons and the construction of a new network of relationships.

In this way, the crisis can lose its characteristic of rupture, of solution of the continuity of existence, and can instead acquire a dynamic value, as contradictory to that existence as it is referrable to it.

Thus the crisis becomes a "historical event" and to a history is returned and rejoined, and in this the impact of the service is often a determinant for in its existence and time it too is a historical event that can create an expropriation or underline and constate the rupture or, inversely, attempt to research and respond. The crisis, in so far as it occurs "in the course of time" can be adequately overcome if the service succeeds in opening or in leaving open for the subject a social space of manoeuvre counteracting the restricting forces in the context that surrounds him, the triggerings of the mechanisms of control, the trapping in the vicious circles of the reproduction of the "illness".

In our experience, the illness-event tends to transform itself profoundly under these conditions, both in its ways of expression and in its evolution. It may decompose itself into things and events that "happen" and it may also repeat itself, but with a different modality and in other times and always "historically".

The service does not propose as an objective the suppression of symptoms, nor does it fix a limit for the "end of the therapy". It wishes, essentially, to offer the tools for social reproduction to the person in crisis, and, therefore, will not necessarily close the therapeutic relationship in short periods of time. The possibility of failure in the therapeutic program obviously depends on both the limitations of the service and the persistence of the illness, viewed as a social signal to be deciphered; and in any case, on the difficulty of therapeutic planning.

Nonetheless, for a local service such as ours, failure in the face of impossible "solutions" becomes the substance of further daily work, because it necessitates the rethinking and reworking of the intervention on the basis of the limits shown; and in any case, the day-to-dayness of the service, its presence as a point of reference for the patient, guarantees a support and the possibility to "carry on", to continue living despite the illness.

The dissolution of the therapeutic relationship, understood as the end to "assuming responsibility", is not conditioned by the misleading sense of cure in the clinical sense, precisely because the problem is to guarantee the continuity of the patient's life within the community. In our view, the termination of the assumption of responsibility is tied to the crisis which occurs in the therapeutic protection when the patient develops the capacity for autodetermination. For this reason, the service treats as secondary the risk of dependency, preferring to actuate transformations in the long term, in which the patient can always develop new needs and new means of expressing them.

In the service-user relation, which is difficult to reduce to the sphere of practices that bear the imprint of the clinical model, it is possible to nurture new means if intervention precisely through the valorization of the patient, of his needs and of his behaviour. In this way, it is possible to demonstrate that an individual call be ill and yet continue to live at home, all the while frequenting a psychiatric service; to demonstrate definitively that psychiatric institutions do not necessarily have to totalize the subject or absorb him to the degree that he is ill for varying durations of his life, but that it is possible to deal at every level with the opposition sickness-health.

Elements, traits, segments and portions that are sane and "normal" are discernible in every "ill" subject and it is always possible to recognize as meaningful and evaluate the nexus between normality and abnormality, between being well and feeling bad, between being able to act and needing help. While clinical psychiatry tends to recognize only those traits that are pathological, abnormal, unhealthy and symptoms of illness, the practice of the service described succeeds in attaching a value to the dialectic nexus between sickness and health and, therefore, to the components that are sane, to the expressions of health and normality.

Even when ill, the subject expresses the capacity for relationships, creativity, original expression, productive and work abilities or, at the least, the need to realize his creativity and productivity.

In this way, the therapeutic relation assumes the characteristics of the process and the continual verification of the program; expectations and solutions proposed.

It is no longer possible, or proper, to refer the "difficult" patient to total institutional solutions.

We conclude by recalling that the real sense of the profound transformation which occurred in the structure of the psychiatric service network in Trieste is the reversal/change in the course of the psychiatric patient, in his means of self-expression and they way in which he is perceived by others.

New areas of research are opening up, new problems await solutions.

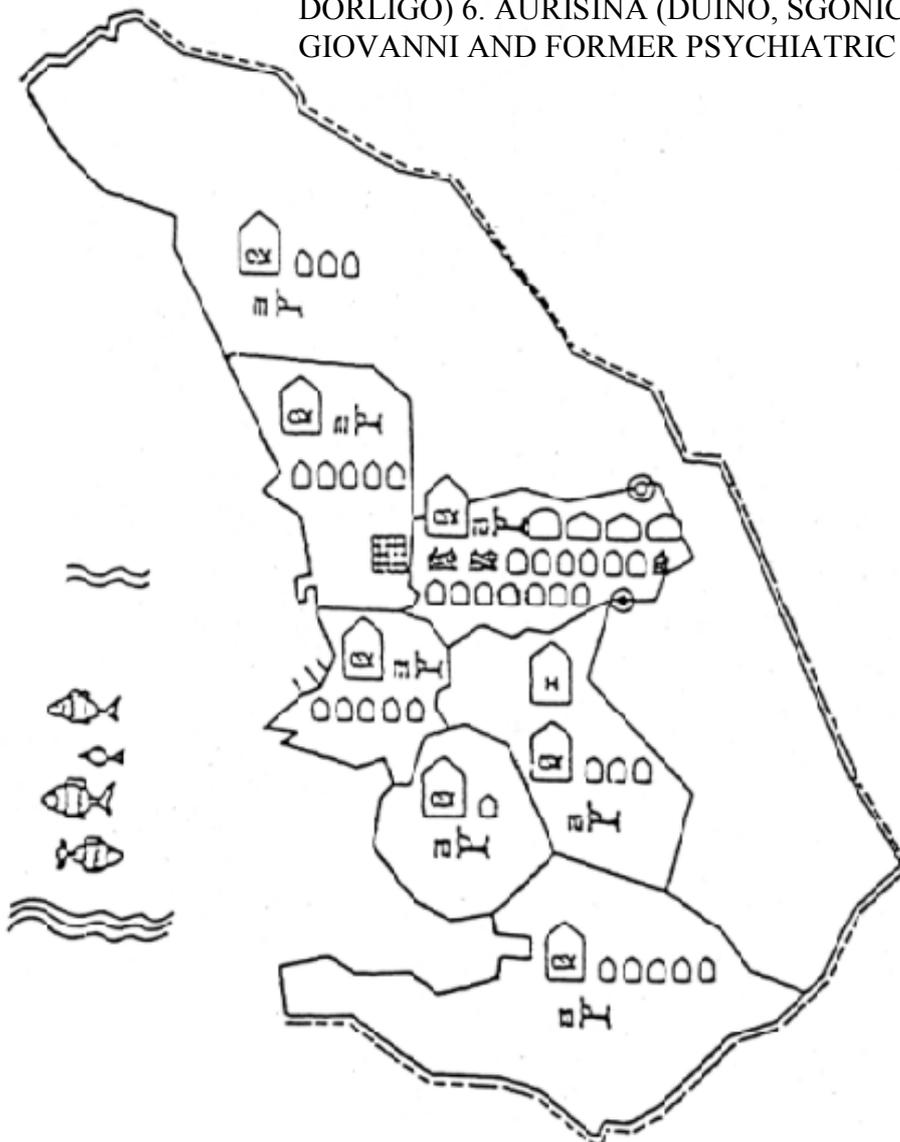Riferimenti bibliografici / Reference

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U.S.L. nr. 1 «Triestina» Set up of the psychiatric care service network.
Areas into which the USL district is divided
1. SAN VITO 2. VIA DELLA GUARDIA 3. BARCOLA 4. VIA GAMBINI 5. DOMIO (MUGGIA, SAN DORLIGO) 6. AURISINA (DUINO, SGONICO) 7. SAN GIOVANNI AND FORMER PSYCHIATRIC HOSPITAL


Surface km^2	211.3
Nr. Of districts	15
Population 1983	281.617
1984	278.426
1985	275.475
1986	274.178
Elderly people %	21,2
	21,5
	22,2
	22,9
N° of municipalities	6

(Trieste, Muggia, Duino Aurisina,
S. Dorligo, Sgonico, Monrupino)

State boundary ------------
Province boundary ==========

Mental Health Centre open round the clock

Flat-group

Hotel-home: residence with more than 10 guests

Service for elderly people

Prison psychiatric service

SPDC: General hospital psychiatric first-aid department

Workshops (theatre, painting, music, tailoring, writing)

Co-operatives (farming, cleaning, building, transport, bar, restaurant leisure time)

CMAS

University Psychiatric Clinic

TABLE 2

BARCOLA MENTAL HEALTH CENTRE – 1985

Total psychiatric calls in the district area (727, equal to 16%)
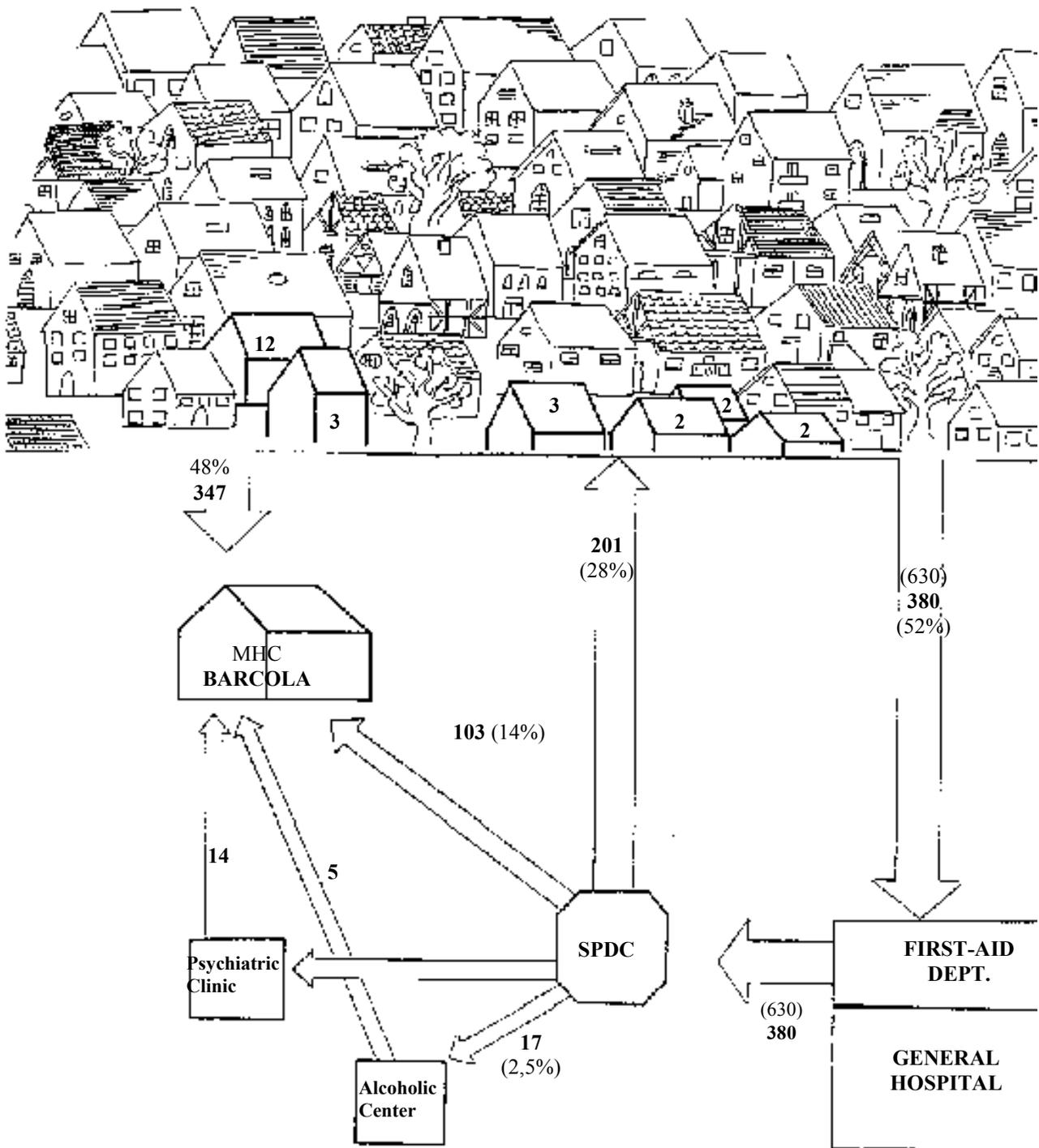
The total number of calls on the Psychiatric Service of Diagnosis an Treatment (S.D.C.) in one year is 630, which is equivalent to 380 people. Of these, only apart (103) reach the MHC; 201 return to their environment without any further interventions and the rest are sent to other services (Psychiatric Clinic: Alcoology: 17).

347 persons refer directly to the MHC. The houses in bold-type represent the flat groups which are directly managed by the MHC, as well as the number of people living there.