Eight plus eight principles

For a collective and community-based psychiatric strategy (towards mental health)

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We are here to consider the following issue: what reasonable actions can be taken today for psychiatry, or, to put it another way, what are the rules for the transition from an archaic psychiatric system to a system which participates in mental health policies.

Today, based on the innovative and critical experiences of the 70's and 80's, it is perhaps possible to identify, in positive terms, what should be done about the psychiatric question and to indicate a general strategy.

If 1% of the world's population needs significant assistance due to a major condition of mental suffering, then we are faced three enormous issues:

a) a significant portion of these persons (especially in developing countries) receive no assistance of any kind;
b) another significant portion receives assistance from structures, institutions and techniques which are inadequate, inappropriate and for the most part ineffective;
c) and still another portion receives assistance from structures, techniques and institutions which are violent, exclusionary, segregative and which have no respect for human rights, thereby providing a cure which is worse than the original illness.

These factors taken together result in the mentally ill still being one of the most oppressed minorities in modern society today, and certainly the most oppressed in absolute terms if one does not take into account a number of limited, local situations.

The first problem, or that regarding the total lack of assistance (especially in third world countries), is well known to most people and beyond debate.

The second problem, that of inappropriate and ineffective structures and techniques and, consequently, the search for those which are the most appropriate and effective, has always been the subject of international scientific debate.

The third problem, that of psychiatric hospitals, has become vitally important in the last few decades. The Italian law which decreed the abolition of psychiatric hospitals in that country in 1978 rendered the debate much more dramatic and marked an irreversible change in the history of psychiatry, although many more years will be needed in order to fully realise its aims worldwide.

Nonetheless, what we have learned from practical experience during these years goes far beyond the fact that psychiatric hospitals must and can be abolished due to their therapeutic ineffectiveness, their role in sanctioning custody and exclusion, the serious damage they cause to the rights of citizenship and their social iniquity.

Wherever the real transformation of psychiatry has succeeded or, on the contrary, failed, as well as the failure of various experiments around the world (and leaving aside the substantial failure of the promises of traditional psychiatry) the essential lesson to be learned is that the three problems listed above must be dealt with together in order to avoid failure by dealing with them separately.

The fact is, we are dealing with a circular situation in which the system's elements have a strong retroactive effect upon one another. This effect can be described as follows:

a) the psychiatric hospital exists because the psychiatric techniques and institutions which provide alternatives to the hospital are used in inappropriate ways;
b) these in turn (the techniques and institutions) tend to conserve themselves as such because (1) there is the psychiatric hospital where they can unload their failures and (2) given that they are not required to deal with abandonment (of persons "resistant to treatment" or without any care at all) the question never arises as to whether these techniques and services are useful for providing a universal right to care, not for single persons, but for the entire population, and thus, whether they are capable of realising the principle of equal and universal right to care and mental health;
c) as a result, because resources are not infinite but often extremely limited and the psychiatric hospital in any case guarantees the control of the cases considered more or less extreme or absorbs most of the resources available and because the psychiatric techniques in use are not suited to providing adequate and lasting assistance to the entire population, abandonment is not dealt with.

There is a lack of clarity concerning the fact that in public health priority must be given to those who are most ill and most in need (a logic alien to private medicine which tends to constantly pervert general and professional ethics and even the very constitution of the various forms of scientific knowledge and know-how) and that, consequently, services, technologies, training and strategies must be organised in order to achieve this aim. Instead, due to the influence of the marketplace, therapies for normal persons continue to grow at an impressive rate and, as a consequence, professionals are distanced from their principal obligations and endowed with techniques which are even less appropriate for the performance of their principal duties.

We would like to offer some considerations with respect to this problem.
On the basis of countless experiences, we know today that the desirable and intelligent strategy is to deal with these three major problems as one and that it is unrealistic to deal with them separately.
Further, and by way of example, the desire to deal with the problem of the psychiatric hospital by either reforming it or shutting it down, has been shown to be a dead-end in those places where psychiatry's social function, modus operandi and utilisation, as well as its management techniques, the knowledge which composes it and its very epistemological foundations have not also been radically re-evaluated and reformed. Or, more realistically, where its positivist, enlightenment-derived and irrationalist conceptions or, even more simply, the possible frames of reference of a sensible epidemiology, have not been critically examined and reconsidered. And, last but not least, where the class origins of the inmates of psychiatric hospitals, the material and structural conditions of the users and service professionals and the effects of the above-mentioned retro-action between services-users-services have not also been seriously taken into account. The absence of this process of critical awareness, with the consequent radical modification of psychiatry's operational practices, as well as its myths and rituals, results in a hopeless situation. Likewise, even where a great number of services alternative to the hospital are created (which happens rarely but has occurred in certain western European countries and in some areas of the USA), failure is guaranteed if these services are not based on a radical re-founding of the values inherent to the procedures, thought and protocols of action, the aims and methods, the operators' work styles; as well as on a radically different social, legal and existential contractuality of the users, and an ethic of responsibility on the part of the professionals which excludes the biological, psychological and sociological reductionism of the problem (as experiences in Germany, Italy, France and Argentina have proven incontrovertibly).
In these cases, the hospital remains a necessity, the cases of abandonment multiply in the streets and within the various forms of trans-institutionalisation, chronicity

predominates and the infinite proliferation of professionals does nothing more than reproduce *ad infinitum* the unchanging rules of the psychiatric system.

In plain words, the problem is not the psychiatric hospital but psychiatry.

The crisis of the asylums is, in any case, clearly evident. The spectacle of major psychiatric hospitals (where psychiatry had sought to do most, had tried to construct its grand utopia) standing run-down and often half-empty from Lisbon to Recife, from Salvador a Rio to Paris and Seville, demonstrate the failure of that utopia; a utopia which had wanted and dared too much, had deceived itself into thinking that it possessed knowledge which it did not possess, had sought to achieve what it did not have the possibility of achieving, and always with the complicity of a society and a historical period which desired nothing more than to finally have a sort of "hygiene of the individual" at its disposal.
But heaven help us if we cannot distil certain essential givens from this challenge which, in the decades which straddled the turn of the century (but also in the post-war period with its contradictory history of reforms), so many governments and countries gave credit to with the investment of resources the vastness of which today astounds us. These essentials are:

a) that the State must concern itself with its citizens even when they are mentally ill and must not be allowed to abandon them to their fate;
b) that there is nothing magical or religious in madness;
c) that madness is not the world of un-reason but a discrepancy, an impasse which is never absolute in the constitution of reason and of a reason which should be as broad as possible and always in question;
d) that we cannot "resign" from the duty of providing care;
e) that for a very small percentage of this marginal population a number of resources – sometimes great, at other times much less so - were invested thanks to psychiatry's scientific self-legitimisation; human and economic resources which were, relatively speaking, extraordinary.

This capital (in the economic sense as well) of individuals and resources accumulated thanks to the utopia of that historical period must not, and cannot be lost only because this utopia demonstrated its fundamental flaw by constructing places of internment and exclusion which became places of blind and ignoble violence. Thanks to them, the social group which in any society is the weakest in absolute terms, has been in some way the privileged object of an economic and human intervention which must be preserved, reconverted and utilised - which must be reinforced and not lost.[1] This capital must be reintroduced into the processes of social exchange. It must be used not for exclusion but for inclusion, not to maintain custody but to cure, not for abandonment behind walls but in order to live beyond all walls. Freedom is therapeutic if it is supported, aided, protected and constructed both materially and socially. If not, then it is a mere legal fiction, an empty formula.

[1] One thinks of the Brazilian paradox where there is debate on how to reduce or close the psychiatric hospitals and there are many who protest against this hypothesis because there exists the risk that people end up abandoned on the street. The debate is extremely lively in a country where in reality the population in the psychiatric hospitals does not exceed 80,000 persons and even if all of them were to end up on the streets (an eventuality which we obviously will do everything to avoid), what would this mean in a country where there are at least 10 million children totally abandoned on those very same streets?
If the 274 billion cruzeiros which the hospitals cost today (1991) are a great deal, as is affirmed by the Brazilian state or, instead, very little in absolute terms, as seems obvious to us (though certainly too much for the hospitals in question), the essential thing here is that it would be extremely unfortunate to lose, through the necessary reduction of beds (which today many are asking the government to do), even a single one of these cruzeiros.

(The essential thing is this: the process of re-conversion in psychiatry has the possibility of functioning, as it already has in many places, as both a guide and locomotive for all other social policies and for the cultural evolution of a society).
Finally, we know much more about mental illness today, however we understand it but particularly if we understand it correctly, than in the past. Which brings us - beginning with the errors and the experiences of many countries, Italy included - to the definition of the main things we know today. These can only be indicated here in very general terms, but no single term can do without them. Thus, to respond to the initial question: what must be done?

We said that the most effective and lasting experiences knew how to respond in a unified way to these three problems:

a) expanding a system of attention/assistance in mental health
b) improving the assistance provided
c) finding alternatives/replacements for responses which are violent, anti-therapeutic and harmful to ethics and civil rights.

Thanks to their capacity to respond to these three issues as one, these experiences were able to provide effective and lasting results. How did they do this? If one studies these experiences, from Colorado to the more successful Italian examples, from Asturias to areas of Sweden, from Canada, Nicaragua, Rio Negro to areas of Lisbon, Madrid, Geneva, Rio Grande do Sul and Santos, we find a certain number of principals in common despite the obvious geographic, economic and cultural differences. These principals can be combined into a single strategy which can be legitimately identified as a strategy for community mental health (CMH) that is collective and community-based. Within this strategy, the following eight principals for the organisation of mental health services[2] can be identified:

1. the fundamental shifting of perspective from the hospital to the community;
2. shifting focus from the illness only to the person and social disability;
3. the transition from individual to collective action with respect to the patient and his context: a collective work strategy which implies at least the following conditions:

3.1 multi-disciplinary expansion of the competencies put into action;[3]
3.2 enhancing the patient's self-help resources;[4]
3.3 enhancing the family's self-help resources;[5]
3.4 educating the general population in order to demystify the concept of danger and the irrational prejudices which surround the mentally ill, with an emphasis on cultural initiatives able to change the social image of illness;
3.5 greatly enhancing the collaboration of non-professionals;[6]
3.6 rethinking the value, in terms of effectiveness, of solely biological therapies as well as only orthodox psychotherapies. These tools (techniques) can obviously be completely integrated into the therapeutic activities of CMH. But the extremely serious vice deriving from the transposition of practices and

[2] Which are absolutely in keeping with the extremely valuable Caracas Declaration WHO/OHO (World Health Organisation/Pan-American Health Organisation) of 1990 and the various WHO recommendations, even if often too general and not explicit enough. The Caracas Declaration is a very important document, the merit for which goes to Levav and Saraceno who drew it up and knew how to have it approved.

[3] For example, psychologists, nurses, social workers, rehabilitation therapists, etc.

[4] Or social enterprise (as the best expression because mediated); also the cultural group and the enhancement of artistic and expressive resources and the peculiar sensibilities which are often present (which has nothing to do with the caricature of art-therapy which is so diffused or with squalid workshops, given that it is difficult to understand why mentally ill persons should dedicate themselves to the expressive arts when "normal" persons quite happily do without them).

[5] That is, associations with specific goals or target-groups

[6] Community leaders, architects, journalists, teachers, artisans, artists, painters, musicians, but also volunteers, students, the general public

techniques which are only tools (as useful as they may be, and in many cases are) into conceptual models for an overall interpretation of illness, is clearly evident. In this way, due either to inertia or totally irresponsible choices, specific practices are taken as the conceptual basis for the organisation of services. One thus passes without continuity and with the tragic perversion of any rationale whatsoever from the value of specific techniques (biological or psycho-analytical or systemic therapies, or whatever) which are completely legitimate in themselves, to biological or psychological, sociological or systemic conceptions of the illness itself (for the most part unproven), and from there to the organisational typology of the services (respectively: purely hospital- or out-patient-based, or private setting, or with a dual reduction of the therapeutic site, etc.). Services of this kind become totally unsuitable, sources of waste and inefficiency; they physically produce distorted images and cultures around the problem, and as such (in the best cases) become producers of chronicity and of an inadequate methodological selection with respect to the needs of users or the population as a whole. Something else entirely is the appropriate (and attentive and critically aware) use of these techniques and therapies within the context of the Community Mental Health strategy. This is the prerequisite for the relative usefulness of these partial actions, which are merely components of a multiple response that must operate on many different levels at the same time;

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

3.8 The open door;

4. The community dimension of collective action. The construction of a theoretical and organisational frame of reference constituted by a specific territory, a defined population and the progressive assumption of responsibility with respect to them, and not with respect to a single institution and the organisation of services which refer to that community and to that specific population.
5. The practical-affective dimension of the actions taken. It is impossible to over-emphasise the therapeutic value which an affective dimension of community work with a rich content of solidarity can develop. The emphasis, especially within the psychiatric hospitals, on the needs, albeit elementary, of the patients and the maximum importance given to collective action in the positive response to these needs and the creation of conditions such that this can occur. One can never insist enough on the value of collective actions capable of modifying in real terms, and to any degree whatsoever, the real living conditions of patients.

These strategies of community actions are completed by:

6. The search for a body of formal rights and legal and administrative norms which defend patients' rights;
7. The implementation of social policies directed at the personal reproduction of weak individuals and the priority which should be given to dealing with housing and employment problems and to the acquisition of capacities/abilities by psychiatric patients;
8. The carefully constructed articulation with administrative and municipal entities/actors capable of capitalising on the action of specialists and of realising a new organisation of the services.

All of this is and should be possible, contemporaneously, and both inside and outside of the psychiatric hospital (this latter is too often overlooked or ignored and erroneously considered as non-feasible).

If these actions are taken together, what we have called community mental health will be able (and experience has demonstrated this in practical terms) to deal with the three issues indicated at the outset on a new basis and with increasingly important results. This will result in significantly expanding the range of persons

being cared for, changing the techniques and methods of intervention and invading and superseding psychiatric hospitals.[7]

For too long now the deinstitutionalisation of psychiatric hospitals has not been accompanied by a deinstitutionalisation of psychiatry, and in some areas this has produced negative or questionable results. No rehabilitation of the psychiatric patient is possible without the rehabilitation – and the deinstitutionalisation - of psychiatry. This conclusion is corroborated by historical experiences both inside and outside of hospitals, in countries both rich and poor, in urban as well as in rural areas. For all these things to happen, new social movements, new participation by patients and a long process of self-criticism by the professional bodies is needed.

From Saskatchewan to certain areas of Molise, from Cinco Saltos to Abitibi, from San Lourenco do Sul to Tolmezzo, Salcedo, the most interesting, innovative and manifestly effective experiences succeed in simultaneously reducing or eliminating internment in psychiatric hospitals, in caring for a large number of users and in creating visible changes in the lives of their patients, invariably through strategies and interventions which are necessarily (and by necessity) community-based. Mr. Lapalisse, one of the more astute epidemiologists among the European psychiatrists, has succeeded in arriving at the obvious conclusion that in order to care for many people it is best to have many people and that the multiplying of effects requires multiplication strategies that one obtains with a great deal of money for many professionals or with the activation of energies which cost much less but with many more persons (non-professionals).
Given that the first hypothesis is practically impossible to realise and, in any case, inefficient, this leaves only the second option. But this option remains nonetheless difficult (like all things which are obvious) seeing that it has little in common with the free market and bureaucracy which are the two concrete variants of the modern State, and therefore not very practical despite its being the only possibility.

This paper is based particularly on the work done with my friends in Trieste, with my many Latin-American friends and with Luciano Carrino and Sandra Fagundes.
Community mental health (CMH) transcends to a great degree the field of psychiatry. What we wish to analyse here are the possible changes in psychiatric activity such that it can make its contribution to the processes of mental health.

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[7] There has been (and still is) a great deal of debate concerning the value of particular "organisational and operational models". Those considered the most creditable (and rightly so) are: the "therapeutic community", the French "sectorial" model, the model offered by the Laborde clinic, "institutional psycho-therapy" and "network therapy". Each of these models has made an important cultural contribution but in the long run they have also all shown radical limitations. Even where the therapeutic community operated in its best and most intelligent forms (Maxwell-Jones, Oury, Tosquelles, Elkaim, XIII arrondissement in Paris, etc), it has subsequently manifested a regression and impasse with the not discountable responsibility of having offered to its followers an ideology "to switch to" and major obstacles to the process of progress in the response to the three priority questions listed above.
In fact, each of these models only deals with one or more of these principles, but no model deals with all of them together and are therefore incapable of achieving all of the goals we have indicated above.

Opening speech at the "First federal psychiatric conference", Brasilia, 1992.