

EMERGENCY AND THE PDCS: THE EXPERIENCE IN TRIESTE (*)

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1. The particular importance of this theme is linked to both general elements – historical, legislative, political-administrative, institutional – and more specific elements related to actual, organised therapeutic-assistance systems created for psychiatric emergencies. These elements can be listed briefly as follows:
 - the entire pre-reform asylum system in Italy was premised on the dangerousness of the mentally ill person, who represented a major social emergency which justified the use of compulsory hospitalisation in terms of custody/care;
 - the legal reform of 1978, by cancelling the principle of danger and introducing that of community-based health treatment, drastically reduced, at least in principle, the emergency situations requiring hospitalisation and established the Psychiatric Diagnosis and Care Services (PDCS) within the general hospitals to deal exclusively with cases of voluntary/compulsory hospital treatment;
 - the piecemeal implementation of the reform law in the various Regions of Italy over a period of nearly 25 years, with the resulting uneven and piecemeal development of the community mental health services, has resulted in an ineffective action for the prevention and reduction of emergencies;
 - the persistence and reinforcing of neo-asylum management models in the diagnosis and care wards where most emergencies arrive, especially physical restraint, locked doors and the use of electro-shock, together with their substantial detachment from the community services of the mental health departments, is a very worrying fact which needs to be dealt with;
 - there exist any number of programmatic documents, recommendations, guidelines and regulations – such as the National Mental Health Goals Plan for 1998-2001, the final report on mental health of the National Bio-ethical Commission for 2001, some regional laws, the charter of rights and regulations of the various health agencies, etc. – which all agree on the goal of promoting and guaranteeing the rights of users by means of an adequate development of services and their commitment to the areas of prevention and treatment (including emergencies);
 - there is the perception of an intensification of deviant behaviours – sometimes of a serious degree – not necessarily linked to mental disorders, which has resulted in an increase in so-called pseudo-

psychiatric emergencies, with a renewed emphasis on psychiatry's function of social control and its never entirely suppressed custodial vocation.

The combination of these elements and the contradictory impetuses which they produce in the organisational systems means that today, in Italy, there is no uniform system of management for Mental Health Departments applied throughout the country. This is particularly true with respect to emergency services. In fact, responding to specifically psychiatric emergencies should mean preventing and re-dimensioning the emergency itself, and giving priority to providing the best possible care. Care here means balancing the respect for the rights and freedom of the person with their need for treatment and the Mental Health Department's assumption of responsibility for such treatment ('shouldering the burden').

2.

What organisational-management models have been used in Italy in this crucial area of psychiatric practice?

In the vast majority of cases, the prevailing model has been based on the combination of part-time community out-patient services and the PDCS. The community services have often operated with consultancy-type criteria, and thus with little possibility of responding to urgent or emergency cases. This has led to the *de facto* delegating of all such requests to general hospital emergency services and the PDCS.

This situation has resulted in the reappearance of 'medical' and 'hospital' crisis or 'acute case' management models, and has kept the small PDCS wards, which are clearly inadequate in terms of both space and resources, jammed with cases for years now. These wards have high levels of Compulsory Medical Treatment (CMT) and an internal 'ambience' which is very similar to the old asylum wards, with locked doors, the physical restraint of patients, massive drug treatments and electro-shock. The frequent lack of co-ordination between the PDCS and the community services has made it difficult or impossible to create co-ordinated therapeutic projects, while the criteria of 'speeding up' releases has resulted in patients in many cases being 'returned' to the community more out of the need to free up beds in the PDCS, rather than due to any real overcoming of the psychiatric disorder, disorders which require a strong commitment and responsibility on the part of the community services after the emergency/crisis phase.

The other aspect of this problem is to be found in the complaints and protests of family members who are often left to deal with difficult

patients on their own, without adequate responses by the community MHC's in periods of crisis/emergency, both before and after the brief hospitalisation in the PDCS (which ostensibly has 'solved' the problem).

Between the accusations of the failure of the reform law and the inevitable, sometimes sensational inability of the public services to fulfil their mandate for care/responsibility, the recourse to private clinics and structures has become, in many cases, the only alternative.

In some areas of Italy, a number of variations in the organisation of emergency response circuits have been grafted onto this prevailing model, with the introduction of teams for psychiatric 'first aid' and, in some cases, with the criteria of mobility in the community, either in tandem with the regular 118 (emergency) services or as an independent, parallel service (cfr. *Trattato Italiano di Psichiatria*, 1992). Finally, there are service models in which the emergency/urgent response (as defined in the previous ministerial goals plan) is a function performed and guaranteed almost entirely by the community services. In this case, hospitalisation is seen as having a complementary function, both as a filter for the demand that arrives directly in the general hospital and as a way of dealing with the more properly medical aspects of certain emergency situations, and involves the direct and unitary management of interventions in close co-ordination with the community psychiatric and hospital teams. The Trieste MHD, together with other Italian mental health departments where de-institutionalisation was carried out and applied directly, thereby anticipating the 1978 reform, is a 'historical' example of this approach.

3.

In the pre-reform organisation in Trieste (until 1977), there was a close relationship between the general and psychiatric hospitals with respect to the institutional itinerary of the crisis. When the person in 'crisis' arrived in the hospital emergency room, and regardless of the nature, entity or reason for the crisis, after a cursory exam by the physician on duty they were sent, in compulsory fashion, to the psychiatric hospital. Given that such cases were included among the 'urgent' cases provided for by the 1904 law (for which law enforcement authorities could 'order' hospitalisation), the emergency room doctor merely prepared a certificate, the details of which were transcribed by the police officer who happened to be present onto a printed form and the patient was sent (almost always under physical restraint) to the asylum. The procedure was automatic and the evaluation and responsibility for freeing the patient from physical restraint and seeking

their consent for any treatment which might be required was delegated to the psychiatrist on duty in the admissions ward of the psychiatric hospital.

In February, 1977, the general hospital attendants who accompanied the patients in the ambulance during their compulsory transfer to the asylum, went on strike and refused to accompany the patients. This resulted, after negotiations, in the creation of a small task force, composed of a psychiatrist and two nurses, which was on-call 24 hours a day and which would intervene in the emergency room every time the on-duty physician considered an admission to the psychiatric hospital to be necessary.

This organisational set-up resulted in a major drop in compulsory hospitalisations. Listening to the patient, freeing them from physical restraint in the emergency room, talking with family members and the relational network and the administration of drugs already available in the general hospital made a wide range of institutional responses immediately possible. These responses included the patient returning home with the crisis resolved (for example, in the case of altercations complicated by the assumption of alcoholic beverages), advising patients and families to initiate a relationship with the community mental health services (already operational in Trieste since 1975) or the patient agreeing to a voluntary admission in the psychiatric hospital. Because more time was now required in order to obtain approval, there were very few cases for which a compulsory hospitalisation was proposed. All accompaniment to the psychiatric hospital was carried out by the mini-équipe in a normal service car. When the psychiatric reform law of 1978 established that all medical evaluations and treatments were to be voluntary and that even compulsory treatments would be carried out by the community mental health centres with admission to a hospital structure only if the centres were unable to do so, it was evident that the emphasis was placed on managing the crisis in the community, with the support of the services. Equally evident was the fact that providing for the creation of small hospital wards (which were given the curious denomination of 'diagnosis and care' services) was the result of a mediation between the radical intention of eliminating a passage through the hospital entirely from the issue of crisis and the fear of a 'deregulation' which would have led to a total absence of response due to the lack of community services, and thus a significant increase in levels of social alarm. Even Basaglia himself, whose actions were generally as pragmatic as they were radical, accepted this compromise due his awareness that the Italian reform law would inevitably be followed by a long cultural, political and administrative battle for the creation of the community services. In Trieste, the creation of the PDCS in the

presence of the MHC's which were organised on a 24hr basis and therefore had the possibility of functioning as crisis centres, was met with considerable discontent and negative reactions.

It was felt, and quite rightly, that in both ideological and practical terms, an institutional passage during crisis in a general hospital dominated by restrictive rules did nothing to further the process of deinstitutionalisation and in any case represented an obstacle.

It was therefore decided to establish the PDCS as provided for by law, but to weaken its functions and meaning. The PDCS would not be a centre for crisis, which was a complex problem best dealt with by the community mental health centres, but a service for that portion of emergencies which, at first glance, did not arrive directly at the MHC's. There would be a close relationship with the hospital emergency room in order to deal quickly with the problem of labelling. Relations with the other hospital wards (consultancy, collaboration) would also be developed in order to 'contaminate' – as Basaglia himself suggested – general medical practice, underscore the importance of social factors in the hospital institution and during the course of illness itself and in order have physical treatment for users immediately available, should the need arise.

The PDCS was equipped with 8 beds instead of 15 (as provided for by law) and with only one full-time physician, with a rotation among all the other psychiatrists in the service on both an on-duty and on-call basis. The principle that the stay and observation period should be as brief as possible and that every user would, in any case, be referred from the outset to a mental health centre was affirmed. Compulsory treatments were not only effected by the PDCS, but also by the community MHC's, and an effort was made to see to it that certain organisational characteristics and the management of the hospital time during the crisis conformed as much as possible to the rest of the system of services. There was thus an emphasis on the problem of consent, respecting rights (negotiation with lawyers and trustees, management of personal effects, mobility, negotiation of drug therapies, a maximum openness and collaboration with the user's family members and social network), managing an 'open door' service and the avoidance of physical restraint (the principles of the 'open door' and 'no restraint').

The PDCS is still organised in this way today, in a departmental perspective which, though indubitably endowing the sum of interventions with a certain coherence, has still not succeeded in eliminating all doubts concerning the hospital time of the crisis and certain recurrent aspects of the contact with the user. The force of attraction of the culture and circuit which feed the hospital demand (in Trieste, for example, there is a strong, traditional hospital-centric

culture), its sometimes inappropriate used by law enforcement agencies or the services themselves and the relationship with the hospital wards and the culture of competencies and specialisations (which still often mask the need to distance and expel those who do not follow the rules) make it an important and delicate crossroads between the services and the hospital, the community and deviance, public order and the need to provide care.

4.

In the Trieste MHD, the PDCS primarily handles those emergencies in the community which do not arrive directly in the MHC's. It is thus organised as a PES (Psychiatric Emergency Service), but with the open door during daytime hours, and is equipped with 8 beds and a medical-nursing teamⁱⁱ. The team's responsibilities are, on the one hand, providing an initial evaluation of the emergency situation which has been referred by the hospital emergency room and, on the other, the rapid connection with the MHD's network of community services, in order to determine whether to initiate a therapeutic project with the user.

The PDCS carries out brief observations (from a few hours to one or two days) and provides voluntary and compulsory hospitalisations in the event that hospitality in a MHC is temporarily unavailable or in cases where there are also medical problems requiring further evaluation (and which obviously do not require hospitalisation in the appropriate medical ward).

Another function is that of urgent consultations in hospital wards (while less urgent consultations are referred to the respective MHC), which is part of so-called 'liaison psychiatry'.

The location of the PDCS within the general hospital and its history (the on-call service until 1980, described above), with its close relationship with the Emergency Room, means that the Service must deal constantly with the model and culture of medical emergency and its strong power of diagnostic labelling.

The problem is certainly complex and regards not so much, or solely, the situations of psychiatric emergency as those situations of so-called social emergency which have been on the increase in recent years and which have been quite rightly defined as 'false psychiatric emergencies' (states of agitation and abnormal behaviours manifested by persons who are unemployed or who have been evicted, by the homeless or an immigrant without a permit of stay, etc.).

In these cases, which in any event arrive at the Emergency Room as urgent cases and sometimes following clamorous outbursts or incidents, one must, on the one hand, not psychiatrise the situation, thereby hiding or covering up the problems and, on the other,

encourage the emergency room doctors to refer these problems to other agencies (social, shelters and aid services). And not only because these cases are not of psychiatric 'competency', but for the proper recognition of the social significance of a problem which is presented as a medical emergency.

With respect to 'proper' psychiatric emergenciesⁱⁱⁱ, the responses provided by the PDCS in its function as a primary filter and location for initial evaluation and treatment, are based on the same criteria as those for community emergencies.

While, as opposed to the crisis in the community, there has already been a release of tension due to the contact with the Emergency Room doctor and team, in the typical emergencies which arrive at the PDCS (acute psychosis, panic anxiety crises, suicidal behaviour), in addition to the person in crisis there is generally also a group of persons in a state of alarm who form part of the context.

It follows, therefore, that the first operational principle concerns the attention given to the 'enlarged' user, that is, not only the designated patient, but everyone who accompanies that person. An approach which is stable, secure and calm, and which knows how to communicate and interact with all parties without assuming that there are privileged interlocutors (the 'healthy' ones) and an interlocutor who is instead the object of care, transmits security, stability and calm and contributes to reducing considerably the drama of the situation.

A second principle is that of acquiring immediately as many elements as possible for evaluation, which in this case should not only be a clinical evaluation (which is advisable, though 'first contact' forms and evaluation questionnaires can always be completed after the initial impact) but above all information concerning concrete facts and experiences involving the patient and those who accompany him/her. Such information can be obtained individually or, if it seems opportune to do so, through a confrontation among the parties involved.

Another principle is that of acting without haste and as a team. Impatience is something which must be banished from the behaviour of all the operators involved in dealing with a psychiatric emergency. Acting as a co-ordinated group is an indispensable resource in terms of an effective approach and with respect to the eventual need for 'holding', which will be discussed below.

At this point, the 'treatment' or care has already begun with the approach. Experience shows that many situations which appear to require an intervention using force, can be at least partially resolved through dialogue, at times intense, but carried out with a willingness to listen and understand, intelligence and a good co-ordination among the operators.

For those situations which cannot be resolved and which require pharmacological sedation, it is important that there be the maximum caution with respect to the drugs and dosages used, and that there be the possibility of a rapid intervention, if needed, by the emergency medical services (first aid services, reanimation). It is in this context that two issues of an operational-technical and medical-legal nature become particularly important.

The first issue is that of 'restraint'.

In the PDCS, as in the MHC, even in situations of great agitation or where there is the danger of physical violence, no one has ever been 'tied down'. Here too, the history of de-institutionalisation has shown the way in terms of the procedures to follow. The reasons for avoiding means of physical restraint in the PDCS has been well summed up as follows (Toresini, 1995): *'There is a substantial difference between physical containment which forms part of a strong inter-human relationship, or the so-called 'holding', which has the affective value of physical caring, to the point of assuming a certain maternal value, and pure and simple containment, or so-called 'restraint'. This latter has a significance which derives from the asylum, no different than the straitjacket, the superseding of which is rooted in the English Philanthropic movement of the mid-19th Century and, even earlier, in the Enlightenment period. In fact, restraining a patient in this way represents an additional danger for the patient, and not only for his physical health but also for his mental integrity, for it can foster a sense of abandonment in a moment when the ego is weak, thereby facilitating the establishment of a state of confusion. Instead, so-called 'holding' is a containment procedure in which one body acts upon another, thereby calling into question not just one but all parties involved and representing primarily a form of communication. Obviously, it is advisable that more than one person be involved in this procedure, to reduce the risk of harming or being harmed. This type of intervention should be carried out firmly but calmly, and with a meta-communication to the patient of the therapeutic intention and the desire to provide care which underlies this manoeuvre. Ultimately, in dealing with the difficult and agitated patient, the emergency therapist cannot avoid placing him- or herself into question, even physically.'*

The second issue is that of Compulsory Medical Treatment (CMT).

In the Trieste MHD in 2001, there were 31 CMT's, or 10 CMT's per 100,000 inhabitants, divided evenly between the PDCS and the MHC from the very start of care. All of the persons who underwent a CMT in

the PDCS, subsequently received additional care (both voluntary and compulsory) in a community MHC.

A research on the period 1978-88 (Sain, Norcio, Malannino, 1989) shows that the rate of CMT's was zero for two years and the highest rate was 5.2 per 100,000 inhabitants, in 1987. Although the rate has increased, we believe that it still remains at a very low level with respect to other areas in Italy of which we have a direct knowledge (national averages are not available). This is an indicator of a generalised effort on the part of the MHC's to obtain consent to care, and to avoid effecting therapeutic interventions against a person's will. In a situation like that of Trieste, the CMT represents a last resort, and is only carried out when repeated attempts to contact the patient and their context – what has previously been defined as the service's 'strategies for getting close' – have not resulted in obtaining a consent to care.

An excessive number of CMT's is definitely an indicator that the community services are inadequate in terms of preventing the worsening of severe mental disorders.

It should also be emphasised and clarified that, with respect to situations of urgency/emergency/crisis, the CMT is not an emergency measure, nor a judicial ordinance and if it is necessary to intervene before the approval by the mayor can be obtained, reference is made to a state of necessity (article 54 of the Italian penal code).

Obviously, acting due to a state of necessity means an assumption of responsibility by the psychiatrists and services of the MHD. However, what constitutes a delicate node here is the state of necessity of a medical nature which is sometimes forgotten or concealed by the state of psychiatric necessity. Clearly, in cases which are not of psychiatric competency, the physicians in the Emergency Room or in the other hospital wards are the ones who will assume responsibility for any intervention.

5.

In conclusion, we feel that the problem of psychiatric emergency must be dealt with in the context of the MHD, as a function which cuts across its entire organisation and especially those of its components which are situated within the community.

The prevailing or total delegation to the PDCS with a reinforcement of the pairing emergency/hospitalisation – especially in the case of PDCS's managed according to criteria of 'maximum security', ie. with reinforced locked doors, generalised practices of physical restraint and an internal atmosphere characterised by the fear of possible violence and thus of maximum control – in fact re-proposes in a flattened,

acritical and condemnable fashion the criteria of danger and custody. As we stated at the outset, these were the basic criteria for emergency hospitalisations in the old asylum regime.

In this scenario, psychiatric emergencies come to represent the negative of the activities and organisation of the community services in the sense that the poorer in resources or more selective in terms of the protocols of acceptance and 'shouldering the burden', the more there will be an intensification of the demand in its worst form as emergency/danger.

It will thus be necessary, beyond any merely verbal declarations, to insist on the necessary economic resources (certainly not less than 5% of the overall general health budget), and to invest in programmes, facilities and human resources.

As indicated in the Goals Plan 1998-2001, only a rich and inter-connected organisation of the MHD is able to :

- integrate itself with other health services, with doctors of general medicine and the with social welfare services and other resources present in the community;
- intervene actively and directly in the community, instead of maintaining an attitude and practice of 'wait and see';
- involve family members;
- make the effort required in order to recuperate the patients who abandon the service;
- give support to the creation and functioning of user and family member self-help groups and social coops;
- carry out training and informational initiatives on mental health aimed at the general public.

Only services of this sort can reasonably hope to reduce and manage emergencies in diverse ways, and achieve the health goals which the Plan defines as priority aims for the prevention/care/rehabilitation of severe mental disorders which result in the disabilities that compromise the personal autonomy and the exercise of the rights of citizenship of the persons who suffer from these disorders.

Bibliography

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ⁱ In Trieste, since 1975 the network of community services has been made up of Mental Health Centres which are autonomous in terms of hospitalisation and hospitality. Some current figures: in 2001, the Trieste MHD, which covers a population of slightly less than 250,000, had 6 operational units made up of 4 MHC's, 1 PDCS and 1 residential and semi-residential service for abilitation, rehabilitation and social reintegration. The MHD also includes the University psychiatric clinic. The catchment area of each MHC is about 60,000 inhabitants. Each MHC operates on a 24 hr basis, has 8 beds, and is responsible for several residential groups which are housed in apartments within the city. Since January, 1999, the University Clinic also has a reference area and is provided with 4 beds (its catchment area has only 12,000 inhabitants). In addition, in each catchment area there are also district mental health out-patient clinics. There is a Centre for problems related specifically to gender and a Consortium of 9 social coops which collaborate closely with the MHD for rehabilitation, job training and job placement programmes. The rehabilitation structures consist of a network of 29 residences (some of which managed by social coops) and training workshops. The PDCS is located in one of the general hospitals and has 8 beds. The MDH has a total staff of 250, made up of 28 psychiatrists (including those in the university clinic), 6 psychologists, about 180 nurses, 8 social workers, with the remainder technical and administrative personnel. The total budget is about ITL 26 billion. Outside the MHD, but in close collaboration with it, there is an association of family members and several self help groups with their own facilities. In addition to the specific institutional activity, there are transversal departmental programmes which concern the training of family members, suicide prevention, assistance for elderly persons living alone, user training and self-help, consultancy for persons incarcerated in prison and relations with gp's and the health districts.

ⁱⁱ The psychiatric team is composed of 2 psychiatrists and 15 nurses. During the night and on holidays or in the late afternoon of working days coverage is provided by doctors on-call or the full pool of psychiatrists in the MHD. Thanks to the organisational set-up, there are nearly daily contacts with operators belonging to all of the MHC teams and the social coops, for the management of patients requiring a care project ('shouldering the burden').

ⁱⁱⁱ A research carried out in 1993 (cfr. Toresini in the bibliography) shows that of a total of 2766 contacts with the PDCS in Trieste, the referrals of a strictly psychiatric nature were 63% of total, with only 19.2% (520 cases) definable as urgent cases – maniacal excitation, acute psychotic decompensation and acute anxiety.

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