

Trieste: The Current Situation

by
[Tim Kendall](#)

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Introduction

In 1992 Franca Ongaro Basaglia, wife of the late, great Franco Basaglia and first senator specifically devoted to mental health world-wide, wrote of the function and social effect of psychiatry as follows:

“The problem of psychiatric illness and its institutions developed in our society primarily as a question of public order. It came into being as a *socio-political problem*, namely the defence of the healthy and working community from elements that would not conform to its modes of behaviour and rules of efficiency.” She continued, “Isolated care and treatment justified the segregation and internment of the ‘ill’, who were considered less for their illness than their potential as disruptive elements. This focus on abnormality and deviance, especially social disruption, meant that subjective suffering was not addressed - nor were the diverse variables giving rise to psychiatric problems. Despite decades of public concern and specific legislation opposing this approach, scientific theories, professional bodies and institutions have resisted abandoning the provision of a style of care that protects society to the detriment of those cared for.” (Ongaro Basaglia, *Int. J. Soc. Psychiat.*, 1992, 38, p36).

The questions raised here are central to the practice of psychiatry and demand answers perhaps more now than in those heady days that gave birth to anti-psychiatry and democratic psychiatry. Who benefits from psychiatry? (Society or the individual?) What are the (socio-political) functions of psychiatry? Can we improve or change psychiatry? If we can then how far is this possible? To what extent is psychiatry merely ideological in its creation of knowledge and categories which form the basis and structure of our interventions? Is a pragmatic psychiatry devoted to the benefit of the patient possible? If your answer is yes, then what would this look like?

I am claiming that Trieste and the Italian experiment are interesting because the mental health workers there have attempted to address these questions, and that in so doing they have acted in an unashamedly political fashion to achieve concrete and practical results. If that sounds obscure just think about the astonishing fact that in 1978 a group of militant mental health workers, patients and others under the auspices of the radical movement for the liberation of psychiatry, *Psichiatria Democratica*, successfully campaigned for a change in the law that made it ILLEGAL

to admit a person to a mental hospital. Nothing like this had ever been done anywhere in the world in psychiatry, and to my knowledge, it has never been repeated. But in Trieste and some other parts of Italy it was not simply the law that changed. Trieste, under the influence of the Basaglias had already begun to shut the mental hospital and to alter psychiatric practice, problematising the whole concept of therapy and developing worker-patient co-operatives from the 1960's onwards.

I first went to Trieste some 11 years ago when I was working as a senior house officer in psychiatry. At this time the changes in Italian psychiatry had become the focus of considerable interest and drew a great deal of antipathy from opponents inside and outside Italy. Psychiatrists in this country, in particular through the vehicle of the British Journal of Psychiatrists under the editorship of Hugh Freeman, were outspokenly critical and at times frankly scornful about the Italian Experience. I went to lectures and talks at this time when psychiatrists would lose their composure altogether denouncing supporters of the Italian experiment as Marxists, Foucauldians, Fascists, Anarchists or simply psychotics. But then psychiatrists have never been noted for their grasp of political or social theory!

The point is that I felt I had to go just to see what was going on. In addition, there was virtually nothing of Basaglia's writings available in English until 1987 when Nancy Scheper-Hughes and Anne Lovell's inspired selection of Basaglia's writings were published as 'Psychiatry Inside Out'. So, Trieste was the undisputed capital of *Psichiatria Democratica* and there I went. I slept, ate, breathed and talked Italian psychiatry for 3 weeks and never left Trieste. I then returned to Sheffield where I was working in an acute psychiatric ward in a general hospital, and on a long stay ward in the old mental hospital, and sank into a depressive stupor when faced, on the one hand, with the inability of psychiatric institutions to care for the individual; and on the other hand, the ever present risk of them doing violence to the patient.

Before I had gone to Trieste I had been systematically seeing and reviewing all the patients on the long-stay ward. Many had not seen a doctor for several years. One of them was a 49 year old man who was particularly difficult to manage. He had been given 800 shots of ECT. Having been in hospital since his late teens, he had been given every drug treatment there was to no great effect. Now he was simply watched since he would take no medication, he fought everyone who tried to do anything to him. A mutual and quite unhealthy, and yet undrugged, wariness was all that was left. Although he spoke "schizophrenese-long-stay-hospital-word-salad", you knew if he was pissed-off with you.

Now this man had the most appalling cough producing about 1 pint of sputum per day, and had lost a huge amount of weight over the 3 or 4 years before. Although he was 6ft tall, he weighed little more than 6 st. I thought he must have bronchiectasis, (holes his lungs) and probably lung cancer. I managed to gain his trust enough to examine his chest and eventually to persuade him to have a bronchoscope. Sure enough he had more holes in his lungs than he had lungs, but no cancer.

Two weeks later I was called to see him urgently since the nursing staff had found him in an angry and distressed state holding on to his groin. When I came in to his dormitory and to near his bed he spat a huge lump of putrid sputum at me; one of his less pleasant signs to tell you how angry he felt. Eventually he allowed me to examine him which was painful and humiliating to him. On examination he had bled under his skin across his perineum including his penis, scrotum and anus- leaving a very sizeable and swelling area in the shape of a large boot. He had

obviously been kicked hard and squarely between the legs but with such accuracy that it was almost inconceivable that this could have been done by a single person. I felt sure that he must have been held down with his legs open. There was no evidence that another patient had done this. The staff claimed to know nothing whatsoever about it.

Two weeks after my return from Trieste, this man was admitted in a coma to a medical hospital with symptoms of starvation, the cause of which was claimed to be self-injection with insulin, despite the awkward fact that he had had no investigations. He was returned to the psychiatric hospital following an injection of insulin which had brought him round. He died two hours later. Post mortem showed that he had died of prolonged starvation caused by a conker stuck in his throat and which, as far as I could piece together, had been there for about 4 years. He had survived by absorbing food through his lungs and he had developed a stomach-like pouch above the conker in his neck. The holes in his lungs were caused by food.

There was no inquiry. I published the story as “The Conker Man” in *ASYLUM*, an English magazine for democratic psychiatry. The consultants in charge of the patient were both seriously opposed to the Italian experiment, and still are. “After all” I would be told, 'Trieste only looked good because Italian psychiatry before the reform was so bad'. But was the English Asylum in reality any better than the more impoverished Italian Asylum? Isn't violence endemic in all asylums?

Origins and History: *Psichiatria Democratica* and Law 180

I now want to turn to Trieste, *Psichiatria Democratica* and the origins of Law 180. To begin with: some factual background to the Italian experiment. It should be borne in mind, however, that I am not an expert on Italy, nor can I read or translate original Italian texts. This is important since there is a paucity of translations of key texts addressing this field and very little of Franco Basaglia's writings have been translated into English.

OK. To the facts. Firstly, Italy had not become a unified nation-state until the 1870's and then only made its first national psychiatric legislation some 30 years later (Mangen, 1989, p 12). Furthermore, although legislation of 1904 insisted on there being an asylum serving each part of Italy, this was not a part of any nationally co-ordinated system of health care delivery, and much of the regional responsibility to provide asylums was devolved to local private institutions, which were not uncommonly religious and charitable. National funding was non-existent. This situation was not essentially altered by the liberation of Italy at the end of W.W.II, especially given the defeat of the left wing in the 1948 elections (Mangen, 1989).

Thus the first serious debate to change Italian psychiatry began in the 1960's. Compare this to England which developed a substantial system of private and charitable health services throughout this century, a proper NHS with national funding in 1945, and a substantial new but not quite revolutionary mental health act in 1959 which paid some attention to the welfare of the patient and allowed voluntary admission.

Italy, on the other hand, was not unlike many other South European/ Mediterranean countries in which conditions for the mentally ill were often appalling (Mangen, 1989). However, Britain differed significantly from Italy, not only in terms of investment in mental health, but also in terms of legal reform and the medical status of psychiatry. In Italy little public moneys were

invested until the seventies, voluntary admission was not possible until the 1904 law was amended in 1968 and psychiatry had no status as a separate discipline within medicine until the 1960's.

Such differences and the evidently inhuman treatment of psychiatric patients in many parts of Italy provoked much public disquiet, a situation that no doubt helped the radical reformers. Indeed, in places such as Gorizia where Basaglia was first made medical superintendent, the Asylums were just too horrible for ordinary people to look at; concentration camp conditions prevailed, and for the interned, including social misfits and the mentally ill, terror and severe neglect was common, if not the rule. But the appearance and smell of these places were valuable tools for Basaglia when he was developing Democratic Psychiatry and gave credence to his strident assertion that psychiatrists had to become politicians within the system. The psychiatric patients' real problem was not their mental illness but rather the way we treated them and how we viewed them; in particular our substitution of the illness for the patient and the subsequent incarceration of the patient in the mental hospital, excluded from the rest of society. Of course, once there, the patient almost inevitably became subject to the most dehumanising and humiliating regime 'where' as Basaglia disturbingly described it, 'medical Ideology [became] an alibi for the legislation of violence' (Basaglia, F. *La distruzione dell' ospedale psichiatrico*. *Annali Neurol. Psichiat.* LIX, 1 1965, in Scheper Hughes and Lovell).

Now, this sounds much like the anti-psychiatric rhetoric of the 1960's and early 1970's; whether the liberal left such as Laing, or the right wing libertarians such as Szasz, whatever else their views, they were all united around an antipathy for institutional psychiatry. However, Laing left it and went private and Szasz never worked in it always having worked privately. But Basaglia was different. He worked in the university and then moved into the asylum to destroy it and to build up something new from its ashes. As far as I know he never worked privately and always remained in the public psychiatric system. His express aim was not to give up power to others who might happily co-operate with an inhuman and often violent system, but to stay in it and to bring about reform from within.

In the early sixties, the Italian reforms were in the mould of the therapeutic community movement, even though they were anti-asylum. However, Basaglia, although influenced by Maxwell-Jones with whom he had previously worked in the UK, began to recognise that therapeutic communities while helping the patient to fit in better, never challenged the society from whence the patient came. In addition, in developing a more humane system of care, the patients ended up idolising Basaglia and his compatriots as their liberators, rather like those who left the concentration camps after WW II had idolised their liberators. However, the patients seemed unchanged in many other respects. In particular they seemed empty and lacking in real personal motivation. Basaglia encouraged them to personally, and with their own hands, dismantle some of the walls, bars and chains of the old asylum. Liberation had to be real, symbolic and active.

The experience at Gorizia was to have a profound and lasting effect on all those involved who then spread across the Northeast of Italy and further afield still in what one commentator and supporter described almost religiously as the 'Diaspora' (Scheper...etc.). Although they were now scattered, these young psychiatrists and mental health workers took with them an experience that for the first time centred around the closure of the asylum and the re-assertion of the humanity of the psychiatric patient. I suspect that they became converts and ideologues.

Basaglia felt that the experiment in Gorizia was only a partial success having been seriously hampered by local political resistance. He moved on to Parma at the request of local politicians and administrators and continued to set up the beginnings of the end of the Asylum. After Parma, Basaglia began this process in Trieste which eventually became the Mecca of democratic psychiatry for Italy if not the world. Indeed, by 1973 Basaglia and Trieste which had become the leaders of psychiatric resistance throughout Italy and with all those who had spread across the north of the country from Gorizia, Parma and Trieste formed the organisation *Psichiatria Democratica* (PD).

PD was a political organisation of mental health workers who were already involved in dismantling the asylum (as in Parma and Trieste) and who were generally left wing. You may have heard that they were “Communists”- some were, but the communist party in Italy is more like the labour party here before Tony Blair. Nevertheless the communist party did not support them; instead the CP. supported an English style NHS and had little understanding of PD. This was later to change.

The basic principles of PD were as follows: Firstly, to continue the fight against social outcasting and exclusion throughout psychiatry, in the work place and in the way madness is represented and perceived culturally. Secondly, to struggle against the asylum as the most obvious and violent paradigm of exclusion. Thirdly, to avoid reproducing institutional mechanisms in the community. And finally, to make a clear link between health and mental health care, especially through the reform of the Italian mental health care system, (S-Hughes & Lovell, 1986, p167). All laudable aims which are all the more interesting when seen in the wider context of similar democratic movements occurring within the Italian Educational and Legal systems at the same time as PD.

But PD is more than this. It is a political support network and a club to belong to and to fight over. Like all political movements it is plagued by infantile object relations and primitive defences (us and them; they’re bad, we're good; they are out to get us; all opposition is bad; etc.). But in this instance, they had more than you might imagine to contend with.

Resistance to *Psichiatria Democratica*

From early on the changes and reforms of Gorizia, Parma, Trieste, Arezzo and Verona were heavily resisted by local VIP’s and the magistrates. The Christian Democrats were some of the more effective in their resistance to *Psichiatria Democratica* which whilst being clinically divergent and politically mixed, nevertheless borrowed from writers such as Gramsci and somewhat later Foucault, perhaps explaining some of the conservative resistance to this radical movement. At different times throughout the last 30 years different authorities have attempted to stop the reforms and to sabotage the movement. This, if anything, inspired those in PD who then campaigned for the national abolition of mental Hospitals.

In 1977 PD helped the Radical Party, a political party primarily concerned with the defence of human rights, to collect together three-quarter of a million signatories to a petition to reform the mental health legislation and thereby to ban admission to mental hospital. Under Italian law this petition could have forced a national referendum on the issue.

To avoid a referendum which could have resulted in the Government being forced to resign, the government introduced Law 180 in May 1978 and thereby initiated the dismantling of the Asylum (and avoided a potentially damaging referendum). Although a relatively simple law with only 8 sections, Law 180 has had a profound impact not only upon Italian psychiatry, but also upon psychiatry throughout the western world. Nevertheless, opinion is divided and both support and opposition is, in the main, “hotly ideological”.

Law 180: The 1978 Reform Act

Law 180 is as much symbolic as it is a concrete change in mental health legislation. Moreover, the degree to which Law 180 has been followed and put into effect varies enormously throughout Italy [See *Acta Psychiatrica Scandinavica*, Supp 316, Vol 71: 'Focus on the Italian Reform', eds. Perris, C. & Kemali, D. (1985)]. Furthermore, Law 180 was not the first attempt to reform the Italian mental health system and its legislation. Indeed, the 1904 act underwent reform in 1968 (the Mariotti reform, Law 431) so as to allow the voluntary admission of patients to mental hospital. In addition, the 1968 amendment repealed the law obliging mental hospitals to register their admissions on a court register, and attempted to limit the size of mental hospitals to 5 wards, each with 125 beds! (It made no mention of an upper limit of persons per bed!). Nevertheless, the custodial nature of psychiatry and its base within the socially marginal mental hospital, alongside the legal powers of compulsory admission meant that few admissions to hospital were voluntary in practice and change only occurred where the mental health workers were committed to progressive practices already (Maj, M. 1985, *Acta Psych. Scanda*, suppl. 316, 15-25).

Law 180 provided for the following:

1. That from May 1978, there would be no first time admissions to mental hospitals thereafter with immediate effect. Anyone who had been admitted already could be readmitted until December 1981, after which time there would be no further admissions to mental Hospitals whatsoever.
2. That for a population of 200,000, 15 bed units (later know as Diagnosis and Cure units) were to be established within general hospitals; these would be allowed to take admissions (voluntary and compulsory) but must work alongside sectorised community based services both serving specified geographical areas. The focus of services must be the community, which the general hospital would back-up.
3. That compulsory admission to Diagnosis and Cure units, if a seriously ill person refused treatment, could only be on the recommendation of at least two doctors, and that a mayor acting as chief local health officer (not as a legal officer) had to approve admission. This is then reviewed by a judge at two days (as with children in custody), and may only be applied for a maximum of 7 days. Compare this to the 1983 MHA in England which allows up to 6 months compulsory treatment and is primarily invoked for those who are dangerous to themselves or others.

It is interesting to compare actual rates of the use of formal compulsion: in Trieste, population about 250,000, in the 8 year period following 1978 there were 24 sections applied. In Sheffield,

pop 550, 000, during the same period, there were approximately 1152 sections applied (that's 12 times every month!). That amounts to about a 24 fold, or a 2,400%, difference in the rate of use per head of population.

Law 180 also specified that

4. The new arrangements in community and general hospital care would retain the full range of existing staff thus protecting the staffing so that redundancies did not follow closure of the mental hospital.

5. No new mental hospitals can be built and existing ones cannot be used as parts of the general hospitals D & C units. (Maj, 1985).

6. Special hospitals and the University clinics were not incorporated into the new reforms.

[For 1-4 see Tansella, M. (1987), The Italian Experience and its Implications, (Editorial) Psychological Medicine, 17, 283-289.] & (Maj, 1985).

Maj (1985) summarised the overall effects as follows:

- Firstly, that dangerousness was no longer used as a criteria for commitment. Commitment was to be restricted to therapeutic emergencies. Secondly, that compulsory admission must be in a General Hospital D & C units, not in a mental hospital. Thirdly, that prolonged hospitalisation was discouraged (with a maximum of 7 days admission for the compulsory patient). And finally, that the mental hospital was officially abolished.

British Views of Italian Psychiatry: the Critiques of Law 180

I'd now like to turn to British views of the Italian Psychiatric Reform, which, with one or two important exceptions, are particularly negative.

When describing the reasons for why we have thought of the Italian experience as a success when in fact it has been a monumental failure, Kathleen Jones, emeritus professor of social policy at York University, Honorary Fellow of the R.C.Psychiatrists and sometime chair of the mental health act commission, suggested that we simply suffered with tunnel vision. Just as tourists do when visiting another country: we tend to take the small and ideal part that we see and mistake this to be the whole of it. Jones and Poletti were in the know. They had been for a two week trip from northern to southern Italy, randomly seeing psychiatric services; a simple and effective method, but completely misguided.

They published this so-called empirical study which was given pride of place as the number one article in the British Journal of Psychiatry in 1985. They commented that "A very basic reason for our excessively rosy view of Italian psychiatry may be that many people in Britain (from the time of Keats and Shelley and the Brownings) have been romantic about Italy. It is the country of art treasures and opera and a superb literature, of warm family life, of sunshine and blue sea and *vino* and pasta. It figures prominently in the holiday brochures." (Jones & Poletti, 1985, p346).

So, Chianti and pasta and sunshine had made us think Italian psychiatry was good. After making many more sometimes defamatory and often gratuitous comments about the 'Italian Experience', Jones and Poletti were so vilified in letters to the British Journal of Psychiatry by everyone who had undertaken more serious research and/or spent rather more time there, they went to visit some of the places where the reform had apparently worked but that they had missed in their "random tour". They visited Roma, Ferrara, Bologna and in particular, they visited Trieste which formed the centre-piece for a further so-called empirical article in the British Journal of Psychiatry, in 1986 (Jones & Poletti, p144-150). The first and most damning article was given pride of place - the No 1 spot in the journal.

Now in this second "scientific" piece, Jones and Poletti praised Trieste for its warm atmosphere, its love of patients, its dedicated and often charismatic staff. They even devoted space to the graffiti:

"It seems no accident that 'graffiti' is an Italian word: the walls of San Giovanni villas express a natural delight in slogans, cartoons, and symbols. On Q ward, now empty, someone noticed that the letter Q looks like a child's drawing of a cat, and added ears. In successive pictures the Q-cat stirs, stretches, and pads away to freedom.' (P146)

Oh! to damn with feint praise!

It is perhaps understandable that the director of mental health services in Trieste at the time, Franco Rotelli, described this paper as a "comic article" which was "a remarkable example of incompetence and ideological distortion full of superficial statements - a revealing example of how unacceptable the Trieste results are for the British establishment", (Rotelli, F., Changing Psychiatric Services in Italy, in Psychiatry in Transition, Ed. S Ramon, p190n).

Now, another piece of graffiti Jones & Poletti failed to mention, but they must have seen, is about 3 foot high and 60 foot long, running the full length of what used to be the superintendents house. It reads "Liberty is Therapy" painted in blood red. You cannot miss it. I am certain they saw it since they mention the house upon which this graffiti has been painted: it had been renamed 'Casa Rosa Luxembourg' (more evidence of the lunatic left) and was given over to patients with much of the antiques left within. As far as I know Franco Basaglia was the first superintendent of San Giovanni Asylum not to live in this house.

Jones and Poletti seem to wilfully misunderstand the Trieste experience. "The Trieste experience appeals to the non-rational side of the human mind". Anyone who knows of the Italian mental hospitals of the 60's and 70's, or has seen the film "Fit it be United" will know how important 'Casa Rosa Luxembourg' and 'Liberty is Therapy' must have been to the patients set free by Law 180. The Triestans called Kathleen Jones, amongst other things, "the black witch" and the "black queen"; such flagrant trashing of the real and symbolic struggles of the distressed and saddened human spirit for many deserved a justifiable pejorative, although "black witch" for some didn't seem quite enough somehow.

But Jones, Polletti and the British Journal of Psychiatry were not alone in their criticism of Law 180. Law 180, as with the 1983 Mental Health Act in England, failed to achieve what the radicals had hoped for. Basaglias Mad Law after 9 years had not produced the profound changes many had expected. In 1988 the Italian National Research Council (CNR) claimed that the reform lacks co-ordinated control, [and that] there has been a deterioration in the quality of care in private and public hospitals", and that "services to hospitalisation are inadequate". Sadly, and

more damning still, the report goes on to say that “at times the psychiatric wards in general hospitals have reproduced some of the worst aspects of the old psychiatric hospitals” (cited in Palermo, GB, 1991, J. Roy. Soc. Med., 84, p101).

Others have focused upon the *abbandonati*: patients who now roam the streets in search of not only community care, but often just simply a home or at least a roof over their heads. Palermo, in an article published by the Royal Society of Medicine cited Italian sources who regarded the Law to have resulted in a fiasco. 'The 800,000 mentally ill are forsaken.... Families live in terror..... Structures and professionals are inadequate... Psychiatrists are sceptical... The law has never been actuated’... In short: Law 180 does not work (Dinni, M & Jerusum, S, 1988, In Palermo, 1991, p101).

But compare Law 180 and the *abbandonati* with 1979 and the rise to power of a very slightly different Black Witch in Britain and the cardboard cities that have grown up since. 50% of those living on the street in London are, or have been psychiatric patients; they now form the largest part of a new and growing underclass that probably dwarf the *abbandonati*. We must not leap onto simple explanations too quickly and without thought. Poor funding is a more likely for homelessness.

Evaluating the Italian experience is a complex affair. Numerous articles exist; indeed, some journals have devoted whole issues to Trieste and the Italian experience including *Acta Psychiatrica Scandinavia* and the *International Journal of Social Psychiatry*. Furthermore, there have been many attempts to scientifically evaluate the effects of Law 180 by a range psychiatrists and social scientists. I will not go into these formal evaluations save to say that, where they have been done in areas such as South Verona (Tansella et al), the results have been promising. The overriding results are that in areas where the changes have been effective, the suicide rate has not increased, the homicide rate amongst psychiatric patients has remained static, the use of formal compulsion has diminished very substantially indeed, and there has been no rise in homelessness nor in the use of private psychiatric facilities. All of this seems to have been the consequence of setting up proper community services without the asylum or mental hospital. In areas where the reforms have been ineffective, the situation is dire and, at times, worse than prior to the advent of Law 180. It appears that, in some of these areas, resourcing has remained a major problem and the change in the law has been used as a reason to disinvest from mental health services.

Trieste Today

I now want to spend a little time describing Trieste as it is now. Mental health services in Trieste are divided into four sectors. In addition, there is the old asylum, San Giovanni, where psychiatric workers, patients, volunteers and the public might meet. Each sector of psychiatry has a community mental health centre with between six and twelve beds attached which are used for overnight stays and sometimes short periods of living for patients and/or their families, sometimes for up to six months. There is a D&C unit attached to Trieste General Hospital and this has a further twelve beds.

As I have already described, the use of the Mental Health Act amounts to no more than three or four times a year. And, as far as I know, only two or three people from the Trieste region have been sent to a special hospital since 1978.

San Giovanni, the old *Manicomio*, has not been shut and demolished/sold/left to become derelict as have many asylums in Britain. Instead, and consistent with the views of PD that the symbolic and the real are intertwined and indistinguishable in many areas, they have not only taken the psychiatric patient out of the mental hospital and moved into the community, but they have also encouraged the community to come into the mental hospital. Indeed, they have an ordinary school now sited within the grounds of the mental hospital and using old mental hospital buildings. Furthermore, they have a drug clinic based in there, a discotheque for the youth of Trieste held every week, coffee bars, restaurants and a whole range of different patient/worker co-operative enterprises. There is also a WHO centre for study and research in the grounds, as is the Directorate of Trieste mental Health Services.

The community mental health centres, one for each sector, are staffed by at least a couple of psychiatrists and usually in the region of 30 or so nurses. They function as day hospitals, day care centres and simply places to go and, in part, a little bit like therapeutic communities. They have the all important daily meeting at the start of the day and they meet with families and patients either alone or in groups in other rooms of the house throughout the day. In addition, each community mental health centre has a small pharmacy within it and drugs are used relatively liberally.

The community mental health centres also function as outpatient departments and utilise medications in this context in a rather strange and certainly unjustifiable way. For example, whilst I was in Trieste, I saw patients receive intravenous infusions of amitryptiline, an antidepressant, which has quite serious cardiotoxic side-effects, given for outpatients who would come-in in the morning and have a slow intravenous infusion over a couple of hours, and then return home in the afternoon.

Although compulsion is said to be at a minimum and certainly this would appear to be so judging by the use of the Mental Health Act, there is nevertheless a regular use of coercion if violence becomes a problem within the mental health centres. For example, I saw that a patient who became quite violent as a consequence of hearing voices insult him and feeling paranoid about the psychiatrist, when he lashed out he was immediately pinned to the floor and given an intravenous injection of haloperidol. This would partly account for the reduced use of the mental health act and is ethically problematic: the MHA ought to help protect a patients rights when coercion is used.

Psychiatrists and nurses based in the mental health centres clock in each day and they are all on the same scales of pay. Nevertheless, the psychiatrists get paid at least twice as much as the psychiatric nurses. In addition, psychiatrists do retain much power and they still have a medical superintendent to whom everybody is responsible ultimately.

Psychiatric nurses and doctors based in the community mental health centres (CMHC) go out regularly to see psychiatric patients in their homes. In addition, in each geographical area are group homes which accommodate people with serious and enduring mental health problems. Some of these homes have nurses living in on a rotational basis whilst others are less dependent.

It has been the express intent of *Psichiatria Democratica* to promote proper employment for psychiatric patients and to integrate psychiatric patients into the community via the workplace. As such, they have managed to negotiate with unions and local employers so that psychiatric

patients should receive proper union rates of pay. To achieve these ends, the psychiatric services set up a series of workers' co-operatives which employ some ordinary workers mixed with psychiatric patients as workers. These co-operatives are partly owned by mental health services and partly by patients. The co-operatives cover a whole range of different activities including cafes, restaurants, vegetable growing, a leather goods factory, a furniture workshop, a seagoing yacht for rent, a bicycle rental service, a hotel, a beauty shop and a radio station. There are also a set of creative workshops including theatre and video making, the later often being used for PR work for the service.

According to Richard Warner, Professor of Psychiatry at Boulder, Colorado, and collaborator with the Trieste group, the Trieste consortium of worker co-operatives produced about £3 million worth of goods per year whilst Pordenone, a nearby town working on similar lines, managed a production of £5 million. These extraordinary outputs clearly will have a beneficial effect on the local economy and whilst Trieste consortia are subsidised to the tune of about 50% by mental health services, in Pordenone the subsidy is a mere 10%.

Conclusion

I began by comparing my experience in Trieste and Sheffield over 10 years ago when I worked as a senior house officer. I hope you could see that although the Italian reforms occurred in the setting of a very backward psychiatric service, rather like the services you would have found in this country in the 30's. Nevertheless, in the better British mental hospital the same violence was and is endemic. The Italian movement PD is right, I believe: the mental Hospital MUST GO. The Question is HOW?

There are many, many good things about Trieste and there are many problems using the law to change attitudes and practices. Nevertheless, if we are interested in the lives, loves and work of people labelled as psychotic patients, there are few places in the world that have, with such conviction and hope, altered the way such persons are viewed and treated. And I don't think its just the Chianti!