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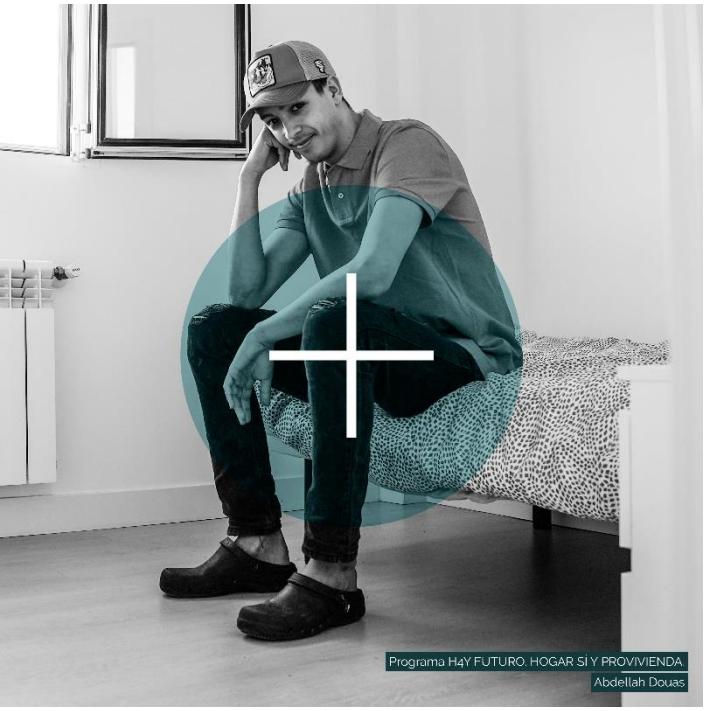
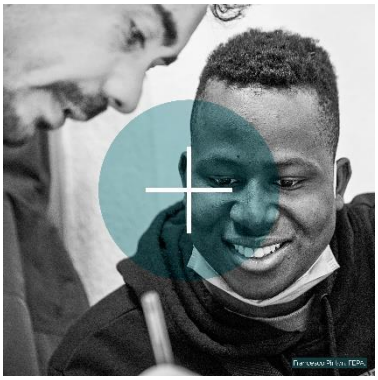
Deinstitutionalisation of Psychiatric Care in

Trieste Region and Italy





Estrategia estatal
de desinstitucionalización
Para una buena vida en la comunidad

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Key messages

This documents portrays the deinstitutionalization process of mental health as happened in Italy since the sixties of the past century, with a special focus on the Trieste region and the town of Gorizia, home of one of the most innovative and impactful social experimentations on mental health care provision, led by Franco Basaglia, Franca Ongaro and a broader collective of practitioners, thinkers and persons with lived experiences, that gathered in the association *Psichiatria Democratica* [Democratic Psychiatry]. The author claims that the Trist approach of deconstructions goes beyond just dissolving institutions, but to deliver viable community-based mental health practices, which depart from a deconstruction of the very notion of mental illness. The key messages are the following:

- The person who is the bearer of psychic suffering is the subject as such and any intervention has to take the totality of the person into account, including its social relations and their structures. The therapists take full responsibility for the person's needs in its entirety, not just the defects of the illness, and the response is addressed to the complexity of needs ("whole life").
- The total and preliminary closure of all psychiatric hospitals is a precondition, as community mental health cannot develop in the presence of the strong 'gravitational attraction' of the asylum. Deconstruction is an alternative and not an addition.
- The process of deinstitutionalisation began with some psychiatrists questioning their own professional role within the asylum as repressive and non-therapeutic institution. The practice of deconstruction constructed a body of alternative thought and alliances were made with other civil rights movements in the broader sense.
- There was initial resistance from certain professional groups, and backward-oriented sections of society. Lawsuits against progressive psychiatrists were reversed by taking the contradiction between care and custody from the judicial level to that of public debates, exposing the inconsistencies of psychiatry, and even leading to *self-incrimination* by doctors.
- The reform process discovered that taking care of people in their complexity fostered the curation and, consequently, makes it necessary to provide 'skills' to the community, to make people understand, to refuse the delegation to psychiatry as a cover (mystification) of the social problems that accompany psychic suffering.
- From the very beginning, the protagonism of users and their families has been the peculiarity of the reform: the general assembly in the first model hospital was run by internees; the establishment of associations of users and their families, the creation of social cooperatives for assistance and job placement; but also, and above all, moments of community participation.
- A distinction must be made between the deinstitutionalization process and reform laws. Laws are necessary, but they are also the inevitable result of political compromises. A law alone cannot bring about significant cultural and social change.

- The retraining of psychiatric staff for communitarian interventions was only possible through the Modell projects. It took a long time, to go beyond the medical approach and establish multi-disciplinary community teams.

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1. Introduction

It is necessary to clarify the word ***'Deinstitutionalisation'*** (DI). In many countries DI is synonymous with discharge from the asylum ('de-hospitalisation'). DI may lead to the abandonment of patients and/or their trans-institutionalisation from the public to the private sector, or it may lead to the creation of community services (Community Mental Health Centres). These services may be more or less effective in prevention, treatment, rehabilitation, without, however, being alternatives to the Psychiatric Hospital (PO), without being aware of the social control functions they perform, without operating a critique of the pseudo-scientific nature of traditional psychiatry.

Having said this, I will refer to the de-institutionalisation implemented in Italy and define this process, more appropriately, as a work of ***De-construction*** **(DEC)**. What does this distinction mean? Institutional deconstruction not only proposes the material end of the Psychiatric Hospital and of all segregating and marginalising structures and apparatuses, but above all proposes the 'deconstruction' of the pseudoscientific ideology of psychiatry and the other 'psi' disciplines in their social impact.

It happens in fact that, beyond good intentions, DI practices end up reducing the complexity of the person's problems to a diagnostic (psychiatric, psychological, psychoanalytic), to a directive and 'normalising' 'management', to the uncritical acceptance of the delegation of social control of diversity. On the contrary, *Deconstruction and alternative construction* can be, puts the complexity of the subject in the centre and departs from a mental health practice as a critique of total, asylum-like institutions and their prioritisation of autonomy, citizenship, and respect for dignity in dealing with the mentally ill. This is identified as '*Basaglia thought*'. And I am not just referring to the writings of Franco Basaglia and Franca Ongaro Basaglia, but to the practice and theory of a *collective subject* (composed of professionals, users, administrators, citizens). This subject has given shape to a theoretical body and a history of practices, fully realised in some Italian and other countries, since the 1960s.

2. *De-construction: Basaglia's de-institutionalisation approach*

2.1. What are the central points of *De-construction* (DEC)?

The key points of departure for Basaglia's thoughts are the following:

- The centrality and prominence of the subject who is the bearer of psychic suffering (for Basaglia: '*mental illness exists, but is to put in 'parentheses': the priority is based on the single human being, his singularity, his rights and the need to respond to it*')
- The realization of a collective, participative and democratic process, which moves in society to bring about a radical change in injustices, responsible for the psychological, individual and collective suffering and discrimination of persons

with mental problems. (It is no coincidence that one of the main associations that drove the reform was called 'Democratic Psychiatry [*Psichiatria Democratica*]-PD)

- The rejection of preformed answers and any 'objectification' of the person.
- Therapists take *full* responsibility for the person's needs. The response is addressed to the complexity of needs ("*whole life*") that generate the person's discomfort.
- The achievement of the highest possible level of autonomy and social contractuality of the person.
- Criticism of the biomedical model of psychiatry does not mean being anti-psychiatrists. It means, on the contrary, affirming a rigorous treatment, with scientific evidence, that contrasts, for example, the dangerous psychiatry of behaviour, implemented by the 'Diagnostic and Statistical Manual of Mental Disorders' (DSM-V), and the excessive medicalisation of the population, stimulated by the pharmaceutical industry.
- The total and preliminary closure of all psychiatric hospitals: it is not possible to develop community mental health, in the presence of the strong 'attraction' of the asylum, which is, in its essence, a place deputed to make social contradictions invisible and to hide the 'failures' of the health system. Deconstruction is an alternative and not an addition. Rights are not recognised gradually: either they are recognised now or they are not.

2.2. Historical trajectory and milestones

The DEC began in the 1960s in a fertile political and social climate, in Italy in Europe, that wanted to renew public institutions, to implement social reforms.

De-institutionalisation experiences were implemented in some Italian mental hospitals. Paradoxically, the backwardness of Italian psychiatry, due to Fascism's prejudices against psychoanalysis, offered the opportunity for radical changes. A main reference was the French Sector organisation and the English Therapeutic Community.

The de-institutionalisation experience that takes place in Gorizia takes on a radical and emblematic value: the doors are opened, electroshock therapy is abolished, and the hospital's general assembly is established. The assembly becomes the place of *conscientisation* and empowerment of the in-patients. The 'words' are not interpreted: they become expressions of struggle and 'liberation'.

A first law in '68 (Mariotti Law), inspired by Gorizia, allowed voluntary hospitalisation within the Psychiatric Hospital, changing the legal status of in-patients.

The book describing the struggle against the asylum and the emancipation process of the inmates in Gorizia - the *'Denied Institution'* - became a publishing and political

success in 1968; it was the cult book of the youth movements.[1] When then, in Gorizia in 1972, politicians wanted to prevent the opening of mental health centres in the area, fearing the uncontrolled spread of *radical ideologies*, the doctors discharged all the 'cured' in-patients and resigned themselves. Thus, the simple 'humanisation' of the asylum is rejected and the Psychiatric Hospital 's marginalising function is claimed.

The experience of change continues and is strengthened in Trieste, which moves in a different political context from Gorizia. The deconstruction of the asylum is accelerated: the "outside" is brought inside the hospital (parties, concerts, debates) and the "inside" is brought outside (meetings in schools, factories). As the hospital apparatus is de-constructed and the in-patients are 'rehabilitated', Community Mental Health Centres (CMHCs) are opened in the territory, open 24 hours a day, which carry out entirely the functions of prevention, treatment, and rehabilitation. A small infirmary in the Civil Hospital responds to night emergencies. In 1977, the Psychiatric Hospital in Trieste was formally closed. The new organisation has much lower overall costs than the previous one.

In 1978, in a political situation of emergency, a framework law was promulgated in Italy (Law 18/78), which established the admission of psychiatric patients only in General Hospitals and allowed persons, admitted at that time in a psychiatric hospital and not discharged, the possibility of remaining there as guests until expiration. The limit for transition is set at one year. In fact, the law dismisses the concept of ‘social dangerousness’ of the psychiatric patient. The territorial network will be constituted by the CMHCs. The law is approved by all parties with the exception of the extreme right.

In 1979, the National Health Service Law 833/78 was established: Law 180 disappeared as a *specific* law and was incorporated into the health law.

In 1980 Franco Basaglia died

In the 1980s, the reform law came under heavy attack. The parliament and the government, which were supposed to regulate the staffing and funding of the new law, are dormant. Various family associations denounce the difficulty of taking on the management of the sick on their own. Various counter-reform projects are presented in parliament. Only the regions governed by the left enact their own implementing laws. The change is implemented in the country in a *patchwork manner*. On the whole, however, public opinion continues to support the law.

In 1983 Franca Ongaro Basaglia was elected senator in the Italian parliament, for two terms: in those years she carried out an intense activity in the Health Commission, making clear the validity of change, where it was possible to achieve it. She promoted the establishment of an Observatory on the law and directed the unease of family members towards denouncing the failure of government bodies, rather than against the

[1] Basaglia, F. (1968). L’istituzione negata. Rapporto da un ospedale psichiatrico. Baldini Castoldi Dalai editore. Milano

law. Finally, in 1984, the first the so-called "*Legge Obiettivo*" [basic law] was promulgated, defining the funding, staffing and functions of the Mental Health Departments. Two years later, the government ordered the closure of the old hospitals and the placement of their residents in small assisted-living facilities. This decision also has an obvious economic saving and mobilises resources for territorial services.

In 2015, another important result was achieved, the result of the constant mobilisation of the *Psichiatria Democratica* movement and the CGIL trade union: the closure of the six Judicial Psychiatric Hospitals, which, being under the Ministry of Justice, had not been able to benefit from the provisions of the health reform laws. In order to accommodate inmates and to respond to the care of mentally ill offenders, small Residences for the Execution of Health Security Measures (*Residenze Esecuzione della Misure Sicurezza Sanitaria* - REMS) are being built, organically included in the Departments of Mental Health. The persistence of certain rules of criminal law and a certain ambiguity in the wording of the law, leave open the issue of the type of security measures to be implemented. However, even if there are contradictory realisations, it is indisputable that the treatment of the patient offender is entirely the responsibility of the health service, which implements rehabilitative purposes and a method of de-institutionalisation.[2]

3. Process

Drivers

The process of deinstitutionalisation began with some psychiatrists questioning their own role within the asylum: a repressive and non-therapeutic role. Thus began a practice of deconstruction and alliances were made with other movements fighting for the affirmation of civil rights (school, facilities for the disabled, factory, prisons). Gradually, through the establishment of *Psichiatria Democratica* **–** an association with no political connotation – intellectuals, artists, representatives from the world of entertainment and communication, trade union representatives and politicians were involved. Young people from the student movement, through *volunteering*, directly participated in the practices of change.

Resistances

There was initial resistance within the hospital from nurses, who defended the privileges inherent in a routine devoid of checks and control. The administrative bureaucracy of the hospital also struggled to incorporate the changes (hindering staff visits to the homes of discharged patients). At the same time, sections of the population expressed fears of an uncontrolled presence of dangerous madmen in the city. The tactic we used was to bring the issue back from the abstract level (the madman) to the concreteness of the person

[2] Mezzina, R. (2022). La pena y la cura. Servicios de salud mental en Italia después del cierre de los hospitales psiquiátricos judiciales. Revista de la Asociación Española de Neuropsiquiatría, 42(141), Article 141. https://www.revistaaen.es/index.php/aen/article/view/17209

(the subject with his name and history). Furthermore, we did not chase the consensus of the majority, but instead sought the convinced involvement of a *minority of* motivated citizens. Even the parties of the left, as institutions, struggled, at first, to recognise the value of the 'revolution' taking place.

Numerous complaints from conservative sectors of society led to numerous lawsuits against progressive psychiatrists, based on the 'repressive mandate' of the old law. The situation was then reversed by taking the contradiction between care and custody from the normative to the social level, opening public debates, exposing the inconsistencies of psychiatry, and even leading to *self-incrimination* by doctors. These trials, after alternating phases, always ended in favour of change. Sentences have emblematically represented the incorporation of change by the judiciary.

Development and evolution of the concept during implementation.

In the beginning there was a simple ethical demand: to fight repression and injustice, to assert the rights of the individual (professional responsibility). Then came the criticism of the pseudoscientific ideology - the biomedical model - that supported the asylum. The observation that in-patients predominantly belonged to the social class of the working class and under-proletariat favoured a social and political reading of the *phenomenon of 'psychic deviance'.* Progressively, we moved towards alliances with social movements and progressive parts of society, which similarly advocated social reforms. Later on, there has been an increasing and rapid appearance on the scene of new players and their incorporation into the support structure of community base mental care models: health professionals, users, their families, other sectors (education, health), the world of culture and entertainment, the world of work.

Discoveries

Listening to the mad, not speaking on their behalf, one discovered the *'rationality' of* their behaviour, the logic of the survival strategies employed in those extreme situations. We discovered the *'knowledge' of the insane* and their relatives about the illness (coping), the need to respond to their needs, which in terms of health are more complex than medical issues alone (*'Freedom is therapeutic'*!). The DEC allowed us to understand that what cures is the taking care of people in their complexity and, consequently, that it was necessary to provide 'skills' to the community, to make people understand, to refuse the delegation to psychiatry as a cover (mystification) of the social problems that accompany (attention: I do not claim that they generate) psychic suffering. Then it was realised that one could no longer 'speak on behalf', that the democratic professionals had to leave room for the real protagonists of care: the people with a psychic distress (recovery). It was realised, in essence, that the contradiction is not madness, but is Life, which, in itself, contains madness, pain, suffering, diversity.

Have the models been piloted and upscaled?

It was a great collective process, involving the whole of society. In the beginning, there was a strong leadership on the part of *Psichiatria Democratica* and the Trieste experience. Rather than addressing the academic world, the focus of the communication was on Civil Society through the mass media. In involving political forces, an attempt was made to 'de-politicise' the issue, seeking the widest possible consensus. By the 1990s, the process began to be better known by international health and academic bodies, until it was incorporated and disseminated by the World Health Organisation (WHO) itself.

Participation

The protagonism of users and their families has been, from the very beginning, the DEC's peculiarity: the general assembly in Gorizia was run by internees; the establishment of associations of users and their families, the creation of social cooperatives for assistance and job placement. But also, and above all, moments of community participation. The experience of Imola is emblematic, where the active presence of citizens was expressed, for example, in the management of the residences of former internees of the OPP; where transversal associations on rights open to all citizenship were promoted, rather than associations of users only; where twinning between the literacy schools of internees and the infant and adolescent schools was realised).

Information on a 'source text'.

The source texts can be found in the first books on the Gorizia experience ("Che cos'è la Psichiatria?", "L'istituzione negata"), in those concerning Trieste and the entire Democratic Psychiatry Movement, through its official channel of information and debate (the journal "*I fogli d'Informazione*"). The *Associazione Psichiatria Democratica* (psichiatriademocratica.org) developed progressively through Conferences, Congresses, periodicals, which were widely attended, always involving important cadres of society: political parties, administrators, intellectuals, professionals, artists, and exponents of the mass media.

The Trieste experience was initially identified as a research location for innovations by the National Research Centre (CNR), as a 'Pilot Experience' by the World Health Organisation (WHO) and subsequently as a Study and Research Centre of the WHO itself. These relationships and connections have naturally broadened and deepened the initial themes and language, but they have also created a fruitful and reciprocal international exchange/collaboration on the topic of Deinstitutionalisation.

4. Specific elements

4.1. Policy and legislation

The approach was implemented with four laws and two Modell projects [*Progetto Obiettivi*].

- First experiences of the humanisation of Psychiatric Hospitals (OPP) (1960s). Significance and hegemony of the Open Hospital of Gorizia.
- 1st Reform Law (Mariotti Law). Radical experience of Trieste with closure of the OPP.
- 2nd Reform Law (Law 180/78). Inclusion of 180 in the National Health Law
- 3rd Law: Law 833(69). Period of legislative non-compliance.
- 1º Mental Health *Progetto Obiettivi*, with organisation chart and definition of resources (1994). Establishment of Health Authorities; delegation of Regional Health Authorities.
- 4st Abolition of Judicial Psychiatric Hospitals (Law 2014).

A distinction must be made between the DI process and reform laws. Laws are necessary, but they are also the (inevitable?) result of political compromises. A law alone cannot bring about significant cultural and social change. It is necessary that, in addition to the law defining objectives, funding and standards, at least three fundamental conditions be fulfilled synergistically: (a) a responsible and continuous involvement of the institutions, both scientific, social-health and educational, and those of the state (at the central and peripheral levels); (b) an active participation of the actors directly concerned (users, their families and professionals); (c) a shrewd promotion policy involving civil society (through, for example, the mass media and social movements). One understands, therefore, how the intensity and combination of these conditions produce heterogeneous outcomes, both between different geographical areas and at different historical moments.

The implementation of each reform law has led to considerable problems, such as te delays in determining resources, determining plans, funding and so on. But the greatest contrast has been the gradual introduction of neo-liberal logic into healthcare since the 1990s. The negative effects were reflected in the principles of the National Health System established in 1969 and, consequently, in the implementation of the Mental Health reform.

4.2. Personnel: professional profiles and retraining

The retraining of psychiatric staff for communitarian interventions was only possible through the Modell projects [*Progetto Obiettivi*] at the national level fifteen years after the Reform Law, to give certainty to the organisation chart of the new services. The medical model of the old psychiatry, centred solely on the professional figures of doctors and nurses, persisted for a long time. Subsequently, the number and functions of

psychologists and social workers increased in the services, but sociologists were totally absent. A new professional figure was introduced in the 1990s: the professional rehabilitation educator. Many professional refresher courses focusing on territorial work have been implemented, however.

Some of the main experiences were the following:

- A major contribution to the DEC has come from 'voluntary work' (by young people, volunteer citizens, foreigners).[3]
- The lack of involvement of academia in the reform has been negative, with the failure to adapt the training of social and health care personnel. The discordance between teaching and working reality continues to this day (with a few exceptions): the training of psychiatrists and nurses refers to the operational models of countries (the USA, for example) where a true Community Mental Health practice is essentially absent.
- To make up for this delay, successful training experiences were implemented, promoted by regional training institutions and by *Psichiatria Democratica*: CME courses for continuing education, sponsored by the Ministry of Health. The Trieste Training and Research Centre has played an important training role at national and international level.

4.3. Management and coordination

As for the coordination within the public administration (vertical - central-municipal, horizontal health-social etc.), in each Local Health Authority (*Azienda Sanitaria Locale* - AzSL) there is a Mental Health Department, which includes adult mental health, neuropsychiatry of minors, alcohol and drug addiction issues. There are horizontal coordination within the company, which deal with Primary Care, Public Medicine, social health services, Geriatrics, etc. There are discussion and collaboration tables with groups of General Practitioners and local institutions (municipalities). The principles and practices of the DEC therefore have opportunities for broad comparison and integration.

4.4. Funding and financing:

When searching for smart financing instruments to trigger the transition and instruments such as seed funding, it becomes clear that the lack of clear funding provisions made services suffer in the first years after Law 180. The Objectives Project later on clarified the necessary funding.

Co-operatives (of social services and labour insertion) have established smart forms of financing/self-financing.

[3] With regard to 'non-professionalism', it is worth recalling the 'Soteria' experience, implemented by Loren Mosher between 1971 and 1983, in the San Francisco Bay Area, promoted by the NIMH (National Institute of Mental Health of the USA).

4.5. Data and evidence

At the level of the Ministry of Health, there was for many years a serious lack on data collection. Unfortunately, no Observatory to monitor the start and development of the DEC and the reform had been created. The first significant data were collected in the 96s, when the total closure of the old asylums took place, and an impressive number of facilities were established throughout the country.

The first National Conference on Mental Health did not take place until 2001 (23 years after the reform) and with various disputes over its organisation. In 2020, a Mental Health Technical Table had been established at the Ministry of Health and a number of thematic seminars are promoted. The second Conference 'For a Community Mental Health' was only realised in 2021. There is a National Mental Health Coordination, promoted by 114 associations at national and local level and a National Coordination of Associations of Family Members of Psychiatric Patients (UNASAM), with a focus on DEC issues. The Italian Association of Psychiatric Epidemiology is very proactive in collecting and analysing data on deinstitutionalisation and the implementation of the reform.

5. Lessons and perspectives

Successful mistakes

Faced with the substantial bureaucracy of some social and health services, we have sometimes had to take on the task of accompanying former patients in their pathways to social inclusion (the frail, needy person cannot be abandoned!): a contradictory role, but one that has ended up representing a model of inclusion, through the effort to make citizens 'competent' and responsible.

Sustainability of the model and prospects for the future reform agenda

The DEC, which started in Italy in the 1960s, is still relevant and proactive. The law, inspired by it, has been proving for 45 years that *a society without asylums* is possible, even to the extent of abolishing Judicial Mental Hospitals. Today, the international mental health landscape has been enriched with important therapeutic horizons - empowerment, open dialogue, recovery – but the continuity between these realities and the DEC is indisputable. We can affirm, without a doubt, that deinstitutionalisation/deconstruction has represented a real change in the scientific paradigm.

And yet, at this moment the Mental Health Reform, in Italy, is going through a situation of serious difficulty, for two fundamental reasons.

- The first is the consequence of a 2001 decision that led to the 'abolition of the provision of control over the acts of local authorities', giving the regions full powers over healthcare. This choice, perhaps theoretically valid, resulted in the

failure to respect the funding ceiling for Mental Health established by the National Modell projects [*Progetto Obiettivi*].

- The second reason, which has already been mentioned, concerns the corporatisation of healthcare, starting in the 1990s. In these years, the logic of liberal managerialism took hold in the public health services, with little attention to the issues of prevention and public health interventions, which are absolutely necessary for the health of the community, as the recent Covid epidemic demonstrated.

Concluding remarks

Today, Italy has, therefore, a society without asylums, but is still 'sick' of 'asylumism'. producing situations of marginalisation (rest homes for the elderly, residences for the physically and mentally disabled, prisons, etc.). Society has not overcome the injustices and the many social and economic contradictions that run through it.

However, we can totally associate ourselves with the words of Franco Basaglia:

> *"L'importante è che abbiamo dimostrato che l'impossibile può diventare possibile. Dieci, quindici, venti anni addietro era impensabile che il manicomio potesse essere distrutto. D'altronde, potrà accadere che i manicomi torneranno ad essere chiusi!*
> *Ma, in tutti i modi, abbiamo dimostrato che si può assistere il folle in altra maniera, e questa testimonianza è fondamentale. Non credo che essere riusciti a condurre una azione come la nostra sia una vittoria definitiva. L'importante è un'altra cosa, è sapere ciò che si può fare. Nel momento in cui convinciamo, noi vinciamo, cioè determiniamo una situazione di trasformazione difficile da recuperare".*
> (Franco Basaglia, 1979)

> *'The important thing is that we have shown that the impossible can become possible. Ten, fifteen, twenty years ago it was unthinkable that the asylum could be destroyed. On the other hand, it could happen that asylums would be closed again!*
> *But, in every way, we have shown that it is possible to assist the insane in another way, and this testimony is fundamental. I do not believe that having succeeded in conducting an action like ours is a definitive victory. What is important is something else, it is knowing what can be done. The moment we convince, we win, that is, we bring about a situation of transformation that is difficult to recover".*
> (Franco Basaglia, 1979)