

Is freedom (still) therapy? The 40th anniversary of the Italian mental health care reform

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On 13 May 1978, the Italian Parliament approved Law 180, universally known as ‘Basaglia Law’ after the name of the leader of the anti-institutional movement which promoted this radical community mental health care reform. Forty years later, Italian psychiatry still runs a community care system, albeit with degrees of solidity and quality very varied along the peninsula. Mental health care is still an integral part of the National Health System, with liberal regulations on coercion and a lowest number of general hospital and residential facilities beds. Recently, Italy has also closed the special forensic psychiatric institutions and brought the care of the mentally ill offenders within the responsibilities of local Mental Health Departments. Over time, psychiatric deinstitutionalisation inspired policies in other sectors of Italian society, such as those regarding physical and intellectual disabilities, education of children with special needs, drug addictions and management of deviant minors. Furthermore, debate about Law 180 has reached and maintained an international dimension, becoming a term of reference for international agencies such as the World Health Organization and the European Commission, for good and for evil. The overall balance sheet of the Reform process would seem mostly positive, though the last decade has seen many threats challenging the system. Mental health care services have been asked to do much more, in terms of care to a larger population with very diversified needs, but with much less resources, due to the financial consequences of the economic crisis. Although there is no evidence of a trend towards re-institutionalisation, intensity and quality of care may have fallen below acceptable standards in some parts of Italy.

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‘Public opinion ignores the problem [of mental hospitals], they want to ignore it. The mentally ill is a taboo subject. Their families hide them. Psychiatric hospitals, such as prisons, are almost inaccessible.’ With these words, renowned Italian psychiatrist Ugo Cerletti (1949), inventor of electroconvulsive therapy, commented on the ‘scandal of Italian mental hospitals’, whose abominable conditions were also reported in some scientific reports by visiting foreign professionals (Lemkau & de Sanctis, 1950). Under the Fascist regime, Italian psychiatry underwent a dramatic deterioration of human rights and living conditions in psychiatric hospitals, due to international isolation, drive towards control of deviant behaviours and even its political use.

Some 30 years later, the passing of Law 180/1978 radically changed the scenario of psychiatric care in Italy. What happened in those 30 years is probably one of the most interesting chapters in the history of psychiatry and what has happened in the 40 years

after the Reform is probably one of the most interesting implementation of community psychiatry around the world, for good and for evil. The 40th anniversary of Law 180 is thus a right time for reflecting, understanding and to get the best out of this unique experience.

What really happened in Italian psychiatry in 1978?

From Cerletti’s complaints to the approval of the Reform Act of 1978, it runs one of the most studied and discussed periods of the history of psychiatry in the 20th century. During this period, the figure of Franco Basaglia, who was certainly the leader of the Italian anti-institutional movement, is definitely prominent. His notoriety in science, politics and culture, undoubtedly places him in the Pantheon of the history of psychiatry of all time (Burns, 2013).

However, beyond the decisive action of Basaglia and his collaborators, the process that led to the 1978 Reform was very articulated and conflictual. It saw the direct contribution of countless professionals, politicians, journalists and opinion leaders. Its result was determined by the harmonisation of very different positions and experiences, ranging from moderate

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reformers inspired by the French *psychiatrie du secteur*, to the more radical anti-institutional movement of which Basaglia was the most prominent exponent (Scheper-Hughes & Lovell, 1987).

This movement was not only an Italian phenomenon. It had fundamental links with the European and American anti-institutional movements, becoming a kind of exemplary experience referenced in every political and social context of those times. Intellectuals such as J.P. Sartre, M. Foucault and F. Guattari did not skimp their personal contribution. It was certainly an ideological, political and social movement that represented the European *zeitgeist* of the 1960s and 1970s (Foot, 2014). In Italy, besides determining the most radical choices in psychiatric care, the movement accompanied, if not even guided, battles for civil liberties such as divorce, abortion and the establishment of the National Health Service (NHS). This movement found in Italy a substantial part of the psychiatric professionals willing to change the system radically, probably because of the ethically and professionally unacceptable and irreconcilable conditions in which psychiatric hospitals were left (Babini, 2014), whereas in other countries most psychiatrists had an attitude of resistance to the anti-institutional wave.

The process that led to Law 180 sprang through various stages. It started with the indignation of public opinion in relation to complaints about the inhuman conditions of asylums, giving way to the resonance of the Gorizia experience conducted by Basaglia (1962–1968), a therapeutic community within a mental hospital inspired by the work of Maxwell Jones in Scotland. Then there were the programmes aimed at humanizing and downsizing psychiatric hospitals in Arezzo, Parma and Perugia and the start of alternative community services in Reggio Emilia. The final steps took place all in 1978. In January, Basaglia announced that the Trieste psychiatric hospital, he was director of, was going to close, first in the world, within the year. In May, Law 180 was approved and admission to all psychiatric hospitals was forbidden. In December, Law 833 establishing the NHS was also approved and psychiatry was fully integrated within it. The celebrated slogan going on the walls of Trieste hospital, ‘Freedom is therapy’, had found its way to reality.

A completely new phase of Italian psychiatry opened up, with the progressive dismantling of psychiatric hospitals (final step only in 1997) and the construction of the community mental health services network, according to a departmental model organised through different levels of protection. The conceptual plot that has led both phases of deconstruction of the asylum and construction of the community psychiatry was the deinstitutionalisation

(DI) paradigm (Basaglia, 2005), whose implication for the present and the future of Italian psychiatry will be discussed later on in this article.

It is far beyond the purpose of this editorial to provide a detailed historical analysis of that period. What is certain is that the 1978 Italian Reform represents an irreversible jump, a discontinuity in the linear process of the history of psychiatry, marking a watershed between before and after. Its consequences were of utmost importance for the subsequent development of Italian psychiatry, but not only.

DI and the making of community mental health care in Italy – 1978/2018

Forty years later, Italy still has a radical community psychiatry system, one of the few countries in the world where community psychiatry has been *the* national policy for such an extended period. However, DI and the community mental health care network developed nationally within a complex balance between federal and regional powers for planning, managing and evaluating health services. Since 1999, all functions related to planning and managing health services are competence of regional administrations, making it technically inappropriate to talk either of a NHS or of ‘Italian psychiatry’. Actually this produced 20 different regional systems, making the peninsula a unique opportunity for scholars in mental health policy and services evaluation to explore commonalities and differences.

The NHS is tax-funded, covers all citizens and absorbs about 7% of the whole GDP. A further 2% of GDP is spent on private health services by individual citizens on a voluntary additional basis. According to the Italian Ministry of Health, mental health sector is provided with about 5% of national health expenditure. However, an analysis carried out by the Italian Society of Psychiatric Epidemiology (SIEP) found that across Italian regions a mean estimate of mental health spending does not go beyond 3.5%, revealing large regional variability and plausible disparities.

The NHS is organised through 139 Local Health Trusts, each caring for a geographically defined population of an average of 270 000 inhabitants. They have full economic accountability and reasonable autonomy in planning, managing and evaluating services. Each trust includes one Department of Mental Health (DMH) that provides comprehensive psychiatric care for the population. It manages the local network of services on a unitary basis and these must provide at least the minimum set of services required by national policy documents:

1. community mental health centres,
2. day-hospital/day-care rehabilitation centres,

3. general hospital psychiatric units,
4. non-hospital residential, medium- and long-term facilities.

What Italian psychiatric services have in common is that they are universal, tax-funded, fully integrated within the NHS, espouse a public health approach, have liberal regulations about involuntary admissions, offer a minimum set of services, reflect skepticism about 'programmes', and are broadly psychosocial in orientation, with minimal degrees of subspecialisation. This is also where the differences start.

The need for specialisation is tackled differently by each regional system. There are few specialised services for dual diagnosis (either substance abuse or learning disability), eating disorders or personality disorders. Specialised clinics for specific disorders, such as anxiety or obsessive-compulsive disorder, are virtually unknown and confined to a handful of university departments, mostly geared to research in collaboration with foreign centres.

Remarkable differences can be found in standards (e.g. number of beds, allocation of resources to each unit within the department) and integration of private services within DMHs, as well as in integration with child psychiatry, drug abuse, learning disabilities services and provision of specialised care for eating disorders.

The picture emerging helps frame the puzzling differences in service provision along three major dimensions: (a) high- *v.* low-resources regional systems (basically a North-Central/South gap), (b) radical community *v.* balanced hospital/community systems, with Trieste and Lombardy at the two ends of the spectrum, and (c) 'generic' *v.* 'partially specialised' systems, with Campania and Emilia-Romagna at the two ends of the spectrum (Fioritti & Amaddeo, 2014; Lora *et al.* 2014).

Forensic psychiatric hospitals were not affected by the Reform process in 1978. Only in 2008, a bill calling for the transfer of all health services from the prison administration to the NHS provided for the progressive closure of forensic psychiatric hospitals. Psychiatric care of the mentally ill offenders is currently provided within the network of the NHS departments, with some 500 beds allocated in small-size residential facilities to provide care for the most difficult patients. Admission to the forensic hospitals is forbidden since April 2015 and the last patient left the last hospital in April 2017. The last tile of the mosaic of DI has been put in place (Barbui & Saraceno, 2015).

Beyond the borders: implications of the Italian Reform outside Italy

Since the beginning, the Reform had a broad international impact, demonstrated by the number of

monographs in international journals that saw to it in 40 years (Perris & Kemali, 1985; Mangen, 1989; Tansella & Burti, 1999; Fioritti & Amaddeo, 2014). However, it is difficult to draw any conclusive judgement about such a complex process, despite the increasing amount of literature attempting some empirical evaluation (de Girolamo *et al.* 2007). The scientific literature about the subject is mostly by Italian authors, mainly qualitative and theoretical. Even today, Italian psychiatry is probably still more debated than known about and very few have analysed the impact that the Italian Reform may have had abroad.

Forty years after Basaglia pioneering experience, Trieste is still a benchmark in Italy and internationally. It is impossible to talk about Italian psychiatry without carefully appraising this experience which is a WHO Collaborating Center in Mental Health, as well as Verona University, which in its turn, under the leadership of Michele Tansella, gained international acknowledgements for its work in social psychiatry and psychiatric epidemiology.

Trieste and Verona have made much of the success of Italian psychiatry abroad. Many programmes of DI worldwide have been carried out with either direct leadership or general supervision of the Trieste team: Leros island in Greece, the whole Reform process in Brazil, planning and implementation of services in several former soviet republics. Throughout these years, it has been at the centre of international exchanges, mostly aimed at supporting DI programmes and build capacity to implement locally community care. Verona has boosted scientific research in social psychiatry, sharing with London and a few other centres the leadership of an international network of scholars and professionals.

Following on the wave of these two centres, the rest of the Italy also has enjoyed decades of rich international collaborations. Italian centres have been part of large multicentre epidemiological studies, such as Naples in EUNOMIA, Rimini in EQOLISE and Bologna in EUGEL. Emilia-Romagna and Veneto regions have been among the partners of the EU commission 'Joint Action on Mental Health and Wellbeing 2013–2016', respectively, for the workpackages on the development of community care and mental health in schools. Again, Emilia-Romagna region in the 1980s and 1990s has collaborated with Pan American Health Organization (PAHO) through direct consultation and supervision of professionals from its departments to country governments in a large programme that was finalised by the Declaration of Caracas, a document that has guided the restructuring of mental health care in Latin America for the next two decades.

WHO Department of Mental Health and Substance Abuse in Geneva has been directed from 1999 to 2010

by Benedetto Saraceno, whose approach to mental health organisation was clearly imprinted by his early experience with Basaglia in Trieste and then enriched by his close collaboration with Michele Tansella and other colleagues of the international network of psychiatric epidemiology. He was successful in establishing WHO action in mental health under the paradigm of DI, using scientific quantitative methods to support its effectiveness. Saraceno's original approach is still visible today in the work of the Geneva Division, aimed at supporting the governments of member states in the adoption of laws, policies and plans in order to downsize and close psychiatric hospitals, a goal still far away in the vast majority of the world's countries. Attention to the protection of human rights and the active social inclusion of people with mental disorders has been the distinctive feature of WHO action over the last two decades (Saraceno, 2007).

What Saraceno represents at the international health policy level, Michele Tansella has been for the scientific community of those who work in the mental health services. His education in England under Michael Shepherd found fertile application ground in Italian social psychiatry, to which he contributed to give international resonance. Starting from studies on the efficacy of biomedical and psychosocial treatments, he first explored the empirical evaluation of mental health services with particular reference to the Reform process in Italy (Tansella *et al.* 1987). With Graham Thornicroft, he then formulated a conceptual framework as a guide to reading and reforming mental health systems, which is still a point of reference (Thornicroft & Tansella, 1999). The very life of this journal, born in Italy for his will and then become under his leadership one of the top ten psychiatric journals in the world, is a testimony to the benefit that Italian social psychiatry has been able to provide abroad.

From DI to recovery: where do we go now?

Forty years after, the balance sheet for Italian psychiatry would seem at first glance quite positive. Looking at the objective elements, Italy has carried out the largest and most radical de-hospitalisation process in the history of psychiatry, implementing at the same time a widespread system of community services throughout the country, albeit with degrees of solidity and quality very varied. The centenary division between ordinary services and forensic services has been overcome, bringing back the mental health care of the mentally ill offenders within the NHS departments; all this without significant impacts in terms of abandonment, criminalisation of the mentally ill, homelessness, social alarm or suicide increase. All in

all Italy is the country with the lowest degree of formal coercion towards the mentally ill, for those whom this represents a value.

Yet the air that breathes inside and around Italian psychiatry is by no means characterised by optimism and pride for these accomplishments. Uncertainties, fears and frustrations prevail, very differently from the bold enthusiasm 40 years ago.

Certainly, the profound transformations that over the decades have crossed the Italian society and reflected on the NHS play an important role. For over 10 years, mental health services have been asked to do much more, with much less and in a much less protective society (Starace, 2016). For the eighth consecutive year, NHS funding has remained unchanged, which in the face of rising costs leads to an effective reduction of about 15%. A survey led by the Italian Society of Psychiatry found that in the past decade staff allocated to community services faced a reduction of about 50%, with a rate of professionals per 1500 inhabitants going down from 0.8 to 0.4. In many regions, mental health funds have fallen far below the minimum threshold of 5%, in some cases reaching at comparable rates to developing countries.

At the same time, the spectre of needs expanded and diversified, under the combined effect of greater psychosocial vulnerability (e.g. the second-generation migrants, the growing population of poor people in the cities, the effect of early use of substances) and the availability of costly technical interventions that are credited with scientific evidence (e.g. psychotherapies in personality disorders, behavioural therapy in autism...). These are problems that afflict all contemporary societies, but that in Italy more than elsewhere seem to creak the plant that 40 years ago was set up with the NHS and with DI in psychiatry.

The DI paradigm means to Italy much more than the closure of psychiatric hospitals. It is a social and political construct designed to reformulate relations between individuals and the society, balancing power relationships in favour of the vulnerable subject. It implies an attitude of constant awareness of the iatrogenic, destructive and dehumanizing effects of heavy institutional interventions and a continuous effort to minimise them. For this reason, any DI-based programme is necessarily a political programme. It also includes a technical component that states how to achieve this balance, working on the environment (rules, access to care, opportunities, support, safeguards, promotion of open social networks...) and on the individual (awareness of rights, promotion of health, control of care processes that concern him/her...).

The DI paradigm had also a profound influence on national and regional policies on pathological dependencies, disability care, approach to juvenile deviancy and other populations.

On the social psychiatry scenario once occupied entirely by DI, other paradigms have emerged over time. They share with DI some goals and methods, but they have interesting distinctive features. In particular, the paradigm of psychosocial rehabilitation and the paradigm of recovery today claim a significant place in setting up health policies. In their purest formulations, both seem to disregard any political dimension. They are instead technical paradigms for working within any given society, with the use of special evidence-based techniques in the case of rehabilitation and with strong support for the personal initiative of the citizen in the case of recovery. However, in both approaches, the component of social criticism of DI is missing. Debate between supporters of these different approaches is high and passionate, as often happens in Italy.

All this poses important questions about what is the future of Italian mental health services. The challenges of today and tomorrow must be tackled with the tools of today and tomorrow. It does not make much sense to regret styles and modalities of a glorious past, but it is wiser to roll up sleeves and accept to carry the ethical foundations of the profession into the forms of our time. Freedom, care, encounter, quality, protection, citizenship, human and civil rights require highly professional staff and adequate provision of resources. Possibly the future can see some thoughtful grafts of rehabilitation techniques and recovery schemes, within a framework of revisited DI policies. Professional challenges must be tackled with confidence and firmness. Looking ahead, aware of a past that should encourage to go further, and not burden the future.

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