Italian psychiatric reform 20 plus years after


Objective: To describe the current situation of mental health care in Italy and implementation of mental health reform legislation.

Method: The current mental health care system and studies of the implementation of psychiatric reform are described.

Results: The 1978 reform law inaugurated fundamental changes in the care system (prohibiting admissions to state mental hospitals, stipulating community-based services, allowing hospitalization only in small general-hospital units). Uneven reform implementation was reported initially. However, in 1984 in- and out-patient services in the community were available to >80% of the population. There is a comprehensive network of in- and out-patient, residential and semi-residential facilities. Recently, services have been jeopardized by the managed-care revolution, and non-profit organizations supplement the public system (especially residential care, employment and self/mutual help).

Conclusion: Implementation of the psychiatric reform law has been accomplished, and the year 1998 marked the very end of the state mental hospital system in Italy.

Introduction

In 1978 the Italian parliament passed an innovative mental health law, Law no. 180, that inaugurated fundamental changes in the public delivery system of services for the mentally ill with a resolute commitment to dispensing with the traditional state hospital by implementing a nationwide mental health system without this type of hospital. Law no. 180 decreed the shift from segregation and control in the asylum to treatment and rehabilitation in the context of society.

History

The Italian tradition of norms for the practice of psychiatry dates back to the eighteenth century when Vincenzo Chiarugi (1759–1820) designed the regulations of the S. Bonifacio Hospital in Florence (1789) according to the enlightened principles of moral treatment. With the unification of the country (1861), the need for a national law became urgent. However, a long period of debates and unsuccessful proposals went by, in spite of the exacerbation of problems related to psychiatric care: in fact, the second half of the nineteenth century witnessed a substantial increase of the number of mental hospitals and inmates. Only in 1904 was Law no. 36: ‘Provisions on Public and Private Mental Hospitals’ passed by parliament. Then, again for a long period (until the 1960s), no new legislative initiative would be taken.

Law 36 addressed social control rather than patients’ health and emphasized the notion of dangerousness. In fact, only involuntary admissions were allowed, with the obvious consequence of discriminating against non-dangerous patients in need of care. A 30-day hold was initiated by a physician, ordered by the police magistrate and registered in personal criminal records. Permanent admission would be ordered by the court and produced the forfeiture of civil rights.
Therefore, the number of inmates of mental hospitals continued to increase in the first half of the twentieth century. Criticism of Law 36 increased after World War II, but only in 1968, as an effect of the movement for deinstitutionalization, were some notable amendments approved by parliament.

The deinstitutionalization movement was led by a psychiatrist with a phenomenological orientation, Franco Basaglia. He and his colleagues took over the state hospital of Gorizia, a small city in north-eastern Italy, in 1961 and were able to transform the hospital completely in the course of the next few years. All wards were gradually opened and patients allowed to move freely within the hospital and in the town. ECT, seclusion and restraints were banned, and a programme of discharge implemented. The original model experimented in Gorizia was then replicated in other cities and became the model for the 1978 Italian psychiatric reform and community mental health system.

The 1978 reform

The movement was able to gain support for the cause of the mental patient from a large number of mental health workers, progressive intellectuals and the public at large, and to gain political support especially among the left-wing parties. In 1977 the Radical Party, already famed for promoting referendums on liberal reforms, launched a campaign for a referendum to repeal the 1904 psychiatric law. To avoid the polls, due in summer 1978, the government hurried a commission inspired by Basaglia to write a new law, which was passed on 13 May 1978 as Law no. 180. Its principal characteristics were the following.

- Prohibition of all admissions to state mental hospitals, including readmissions; however, existing mental hospital patients were not forcefully discharged to the community, thus prevention of institutionalization rather than deinstitutionalization was intended.
- Implementation of community-based services responsible for the full range of psychiatric interventions.
- Prescription of voluntary and involuntary hospitalizations only in emergency situations, when community alternatives have already been tried and failed. Hospitalization takes place in small units (no more than 15 beds) located in general hospitals. The departmental organization of in- and out-patient services must ensure comprehensive interventions for the prevention and rehabilitation of psychiatric discomfort, besides the care of mental illness.

The new services were designed to be alternative, rather than complementary or additional to mental hospitals. This aspect is relevant considering the role of the mental hospital in bringing about secondary disability and handicap in the form of institutionalism. It is also well known that where new services were simply added to the existing system, they did not prevent appreciably the institutionalization in psychiatric hospitals of patients with severe mental illness, since the new services recruited different, less disturbed types of psychiatric patients.

In the international scenario Italian reform is not unique, since deinstitutionalization and the concurrent expansion of community-based services is an inexorable process in all developed countries. However, it was and, largely, still is the most radical one in dispensing with the psychiatric hospital. For its drastic implementation of the principles of community mental health, the Italian reform was saluted with contrasting reactions.

Difficulties

The operation of the reform has been grossly uneven across the nation, at least for a number of years, since regional governments had to pass implementing legislation and look for funds in the already meagre finances of health services at large. A steep gradient in terms of quantity and quality of services between the north and the south of Italy has long been reported and was used by the opposition as proof of the supposed failure of the reform. However, as early as 1984 a nationwide research implemented by CENSIS, a reputable Italian organization for social studies, showed that both in-patient and out-patient services had been developed throughout the country and were available to more than 80% of the Italian population in their own catchment areas. In fact, 675 community services of 694 Ulss (Local Health Districts) were active. At the same time, 236 general hospital units had been developed, with 3113 beds (5.4 per 100 000 population: 60% of those planned). These units totalled about 80 000 admissions a year, one-fifth of which were involuntary commitments, one-third readmissions. The overall rates of in-patient care in 1984 (332 per 100 000 population, including both the public and the private sectors) were lower than those reported before the reform, in 1977 (389 per 100 000 population).
Thus the closure of the front doors of state mental hospitals, while preventing the institutionalization of new patients, did not give rise to the revolving-door phenomenon in general hospital units, nor a shift to the private sector. A number of residential facilities had been established, with 2901 beds (5.0 per 100,000 population), but their number was still considered inadequate to meet the needs of residential care. At the time of the survey, the number of state hospital in-patients had decreased by half, from 60,000 before the reform to less than 30,000. However, the quality of care was generally poor and declining, a handful of programmes for rehabilitation and discharge were active and only few contacts with community services for conjoint resettlement plans were established (1).

The National Mental Health Plan

After several failed attempts and the concurrent presentation of proposals to repeal the reform, in 1994 parliament finally passed a national mental health plan. It had both the political effect of acknowledging the path indicated by the reform 16 years earlier, and the administrative one of providing the regions with common standards with which to operate and finance the services. The Plan prescribed the integration of all local mental health and human services under one administrative organization: the Department of Mental Health (DMH), typically responsible for a population of 150,000, providing the following services.

- Community Mental Health Centre (CMHC): it offers out-patient care and emergency intervention, counselling and support to families, case management, welfare interventions, rehabilitation and vocational training, job finding, hospital gate-keeping, and resettlement of discharged mental hospital patients.
- General hospital psychiatric wards (GHPW) with one bed per 10,000 population.
- Semi-residential facilities, with one place per 10,000 population. They include day hospitals and day centres.
- Residential facilities with at least one bed per 10,000 population: they offer long-term care in small (20 beds or fewer) home-like facilities to the chronically mentally disabled (including former mental hospital in-patients).
- Group homes.

The staffing of the DMH should be adequate, with at least one mental health worker per 1500 population.

In 1998, a National Mental Health Plan for the years 1998–2000 was issued; it incorporated the system structure and quotas of the preceding plan, while stressing a number of goals in different directions, especially dealing with the integration of mental health services with other ones, and quality assurance:

- integration with other health and human services;
- integration with universities;
- integration with local administrations;
- integration with non-profit organizations;
- participation of user and family organizations;
- information;
- evaluation of efficacy and effectiveness of interventions;
- evidence-based medicine;
- quality assurance;
- standards for the certification of services;
- planning interventions;
- setting guidelines; and
- reorganization of the service delivery system for children and adolescents.

The accomplishment of the network of services

The 1990s witnessed the accomplishment of a comprehensive network of in-patient and outpatient services all over Italy and the implementation of residential and semi-residential facilities, such as therapeutic communities, day centres and sheltered workshops, which were badly lacking at the beginning. A recent review by de Girolamo and Cozza (2) portrays a comprehensive network of public and private services covering the whole nation, without the gross unevenness among regions that had been deplored for years after the reform. The Provision of services comprises 10,083 acute psychiatric beds (4084 in general hospitals, 7 per 100,000 population, a figure close to the recommended standard of 10 per 100,000; 404 in university departments; 5595 in the private sector) with an overall rate of 17 per 100,000 population. The rates of admissions to general hospital psychiatric units have continued to decline: 278 per 100,000 population in 1987, 222 in 1994 while those to the private sector have remained stable: 155 in 1975, 140 in 1994. Notably, compulsory admissions have been decreasing steeply (50% of all admissions in 1977, 20% in 1984 and 12% in 1994). Community mental health centres amount to 695, 1.8 per 150,000 population (the size of a typical local health unit).
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Carer and patient groups

Family organizations were active in voicing discontent with Law 180, especially for the shortage of residential services in the early years of the reform. However, they were supporting the full implementation of the reform rather than its abrogation. Family organizations are consulted regularly by the national and regional governments as to planning and law-making and their representatives participate on DMH advisory boards. In 1993 several organizations united to form UNASAM, the National Union of the Associations for Mental Health, which has been very active both nationally and internationally and can be reached on the Web [www.unasam.it]. The (ex)user/survivor self-help movement is also spreading increasingly throughout Italy. It

Table 1. A basic list of studies on the process and outcome of the implementation of Law no. 180

<table>
<thead>
<tr>
<th>Author and year of publication</th>
<th>Study design and goals</th>
<th>Findings</th>
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<td>1. Use of services</td>
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<tr>
<td>Tansella and Ruggeri 1996 (7)</td>
<td>Patterns of care over a 15-year period</td>
<td>The number of contacts and of community long-term users was still increasing</td>
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<tr>
<td>Synta et al. 1998 (8), 1999 (9)</td>
<td>Service comparison across European countries</td>
<td>Italian community-oriented services rely less on hospitalization than Dutch and British ones</td>
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<tr>
<td>Gater et al. 1995 (10),</td>
<td>Service comparison across Italian regions</td>
<td>1-year reported prevalence of community long-term users varied among different case registers between 0.8 and 4.4 per 1000 population</td>
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<td>Veitro et al. 1993 (11)</td>
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<tr>
<td>2. Characteristics of patients</td>
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<tr>
<td>Bollini et al. 1986 (12), 1988 (13)</td>
<td>Characteristics of patients in two groups of mental hospitals</td>
<td>In-patients were older, less educated and more chronically disabled than other mentally ill people treated in the community</td>
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<tr>
<td>Marino et al. 1996 (14)</td>
<td>1-week survey on 3845 patients treated in 47 community mental health centres</td>
<td>Patients served were socially deprived and severely ill</td>
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<tr>
<td>Mattioni et al. 1999 (15)</td>
<td>Use of services of 1371 patients treated in general hospital psychiatric wards</td>
<td>Patients were mostly psychotic, with repeated admissions</td>
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<td>3. Outcome of mental hospital patients</td>
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<tr>
<td>Saraceno et al. 1984 (16)</td>
<td>Characteristics of mental hospital patients</td>
<td>Mental hospital patients had lengthy histories of psychiatric hospitalization, with a small but significant subgroup exhibiting violent behaviour</td>
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<td>Bollini and Mollica 1989 (17)</td>
<td>Number of former MH residents hosted in institutions for the elderly</td>
<td>Low rates of transinstitutionalization</td>
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<td>Valentie et al. 1997 (18)</td>
<td>Mortality rates in 533 long-stay mental hospital patients in central Italy</td>
<td>High standardized mortality rate (SMR) especially in younger patients (SMR = 43.6 in males and 97.5 in females)</td>
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<tr>
<td>Barbato 1998 (19)</td>
<td>Outcome of former MH residents hosted in institutions for the elderly</td>
<td>Low rates of transinstitutionalization (i.e. the transfer to another institution)</td>
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<tr>
<td>QUALYOP study (20);</td>
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<td>D’Avanzo et al. 1999</td>
<td>Closure policies of 22 mental hospitals, regarding 4493 patients in 1994–96</td>
<td>20% of the cohort aged ≤ 50: 25% ≥ 70. 1/2 schizophrenic, 1/4 mentally retarded; 49% in hospital ≥ 30 yr. 2/3 + no significant behavioural problem. Independent living skill full in 41%; almost complete in 24% more. Discharge scheduled within 12 months for only 11%</td>
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<td>4. Outcome of community patients</td>
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<tr>
<td>Kemali, Maj 1988 (23)</td>
<td>Outcome of 116 schizophrenic patients treated in six different Italian cities</td>
<td>Patients treated where comprehensive community-based psychiatric services were available showed greater improvement at follow-up</td>
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<tr>
<td>Mignolli et al. 1991 (24)</td>
<td>7-year follow-up of one cohort of mental hospital patients and one of community patients with schizophrenia</td>
<td>At follow-up mental hospital patients’ symptomatology and social performance either unchanged or deteriorated. 1/2 community cohort improved in regards to symptomatology, 25% in social performance. No patient in community sample hospitalized on a long-term basis</td>
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<tr>
<td>Lesage et al. 1991 (25)</td>
<td>Community patients ‘need for care’ assessed with a standardized questionnaire</td>
<td>Few patients were found to have clinical or living skills problems unmet</td>
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<tr>
<td>Barbato et al. 1992 (26)</td>
<td>Outcome of 559 patients discharged from 21 GHPWs</td>
<td>High readmission rates and indexes of good community functioning, variability of care and variability of outcomes</td>
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<tr>
<td>Terzian et al. 1997 (27)</td>
<td>A 5-year prospective study of patients with functional psychosis followed by 76 out-patient centres</td>
<td>Early results indicate that a substantial proportion of patients showed a favourable outcome</td>
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<td>5. Satisfaction and quality of life (QOL)</td>
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<tr>
<td>Ruggeri 1996 (28)</td>
<td>Expectations and satisfaction of patients, relatives, and professionals with South-Verona community services</td>
<td>Patients and relatives expressed similar expectations and were mostly satisfied</td>
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<tr>
<td>Warner et al. 1998 (29)</td>
<td>QOL of schizophrenic patients in Bologna (Italy) and Boulder (Colorado)</td>
<td>Italian patients scored better in QOL, but this seemed more an effect of living with the family (74% lived with their family in Bologna vs. 17% in Boulder)</td>
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<td>6. Studies of family burden</td>
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<tr>
<td>Gallio et al. 1991 (30)</td>
<td>Burden in family caregivers of 267 patients randomly recruited for interview in Trieste</td>
<td>Reported difficulties included negative changes in family life, fatigue and reduced family income</td>
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<tr>
<td>Veitro et al. 1993 (31)</td>
<td>Patient social disability and family burden on 52 long-term patients</td>
<td>High level of burden found among carers, including poor social relationships with others, depression and deteriorating physical health</td>
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generally tends to adopt an attitude of collaboration with, rather than opposition to, the psychiatric establishment.

**Managed care and the closure of mental hospitals**

In recent years psychiatry, as well as the national health service at large, have been deeply influenced by the managed-care revolution. Mental health services are now more in jeopardy than other more lucrative and politically attractive medical facilities and have to face a fierce struggle in competing for funds and personnel than ever before. For these and other reasons, the importance of non-profit organizations is growing in terms of integrating the public system especially in the fields of employment (worker cooperatives) and self/mutual help.

The very end of the state mental hospital system in Italy was finally accomplished by the Financial Law of fiscal year 1996, which initially mandated the closure of all state mental hospitals by the end of 1996, later postponed to 31 March 1998. Ironically, economic recession and a completely new concern to decrease health costs succeeded where good will had failed for almost two decades. Between 1996 and 1998 26 mental hospitals were officially closed and the number of patients dropped from 17 068 (on 31 December 1996) to 7704 (4769 in public and 2935 in private mental hospitals on 31 March 1998).

**Studies on the process and outcome of the implementation of the reform**

It is commonplace to lament that Italian reform has not been monitored adequately in a scientific way. In fact, de Girolamo (3) and de Girolamo and Cozza (2) and other authors (4–6) have reviewed a considerable number of studies on Italian reform published in national and international journals (Table 1).

At present, the mental health system is deeply involved in implementing a new national health plan at the regional level.

In conclusion:

a) the block of admission to mental hospitals, in operation since 1982, certainly prevented the institutionalization of a massive number of people. Whether it may be preferable to study in detail small experiences of deinstitutionalization in order to provide empirically sound directions for future use, or to dare to care in the immediate present for thousands of patients in the community while preventing their institutionalization, is a matter of political choice rather than a scientific decision. At least, history seems to prove that the former method is more common than the latter;

b) wards in general hospitals and community services replaced the state hospitals without an increase in the revolving-door phenomenon. Yet, the number of admissions shows a steady decreasing trend;

c) a complete network of services is generally accessible to citizens in their own communities without the wide difference across the nation, as in the early years of the reform;

d) residential facilities are also available in numbers well above the recommended standards.

The bottom line is that Italy has shown in practice, for almost a quarter of a century, that it is possible to do away with the mental hospital and to provide a nationwide system of psychiatric care according to the principles of community mental health.

**References**


