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Opening address to the WAPR Congress, Paris, May 8, 2001

May, 1978, Law 180: the Italian state legislates the end of the psychiatric hospital.

Today, despite the delays in applying the Law and the obstacles interposed by local administrations, despite medical power and political manipulation, we can say that the walls of the psychiatric hospitals have finally been knocked down.

Number of patients in psychiatric hospitals
ITALY

Year (on Dec. 31)	Patients
1977	58,000
1978	48,000
1979	42,000
1996	11,783
1997	6,658
1998	2,364
1999	221

Thanks to these figures which do away with the psychiatric hospital, we could already conclude this address. These figures seem to me important for a congress on rehabilitation because they indicate the progressive rehabilitation of psychiatry. In fact, we have always maintained that psychiatric rehabilitation must begin with the rehabilitation of psychiatry.

Everyone has always denounced the psychiatric hospital in cultural terms. The ‘small difference’ in Italy was that this denunciation was taken seriously, in concrete, real terms. Today, this choice still needs to be made, and constitutes the primary characteristic of deinstitutionalisation.

Twenty years is a long time for verifying a law. During this period, it was written and said that the Italian law was the result of ’68 and that it would be rapidly changed. However, it still exists today and another law, n. 724 of 1994, has confirmed and developed it further.

It was said that it was a law of the extreme left. Mr. Berlusconi’s government of a few years past, issued a decree in order to extend its effects.

It was said that it would have reduced psychiatric care in Italy to almost nothing and that, in the end, its only effect would be that of saving money for the State. Two months ago the Italian government and the Regions agreed to allocate, on a regular, long-term basis, 5% of the annual Italian health budget to psychiatric care. The budget of public psychiatric care in the year 2000 was ITL 6,000 billion, the equivalent of 3 billion dollars, or 20,000 million Fr. Francs.

It was said that the law was supported only by a radical minority of psychiatrists, but next September the Italian Psychiatric Association, which has 6700 members, will organise a Congress in honour of Franco Basaglia and currently supports both the Law and the National Plan approved this year by the Government for a further development of community services.

For years we have said that deinstitutionalisation *is not limited to* merely shutting down the psychiatric hospital, but involves the modification of psychiatry's cultural, theoretical and scientific paradigms (which actions have as their indispensable, though in itself insufficient condition the end of the asylum).

Breaking the clinical paradigm was the true aim of the deinstitutionalisation project. Breaking the paradigm also means disrupting the mechanical relationship of cause and effect in the analysis of the constitution of madness.

Negating the institution was, and still is the desire to dismantle that linear causality (much more so than dismantling the hospital) in order to reconstruct a concatenation of possibilities-probabilities, as all the modern sciences teach us to do with respect to complex objects. The project of deinstitutionalisation coincided with the reconstruction of the complexity of that object which the old institutions had simplified (and it is no accident that they had to resort to violence in order to achieve their aim).

In the Italian reform, the practice of deinstitutionalisation indicates an itinerary of deconstruction, starting from within the psychiatric institution, which frees up very complex energies.

An elementary example of this in Italy is social co-operation which began with the transformation of the status of patients who worked within the psychiatric hospital into associated workers, and recognised as such, and has developed gradually into a tool for the re-integration of different vulnerable groups.

Social co-operatives in ITALY

Year	n. of co-ops
1985	650
1990	1,800
1993	2,180
1994	2,312
1995	2,834
1996	3,661
2000	4,250

Year 2000

- **2815 social assistance co-operatives**
- **1445 social co-operatives for job-training/placement (30% of members from vulnerable groups)**
  for a total of 127,000 members
  and a turnover of Euro 1.549 billion

As is well known, the process of implementing the Law over the last 20 years has gone through phases of acceleration and delay. Throughout the entire national territory, alternative services have been bit by bit created, though not in a uniform manner. The commitment to creating new services has been very significant and real in certain areas of the country, as the following table shows:

ORGANISATION OF MENTAL HEALTH DEPARTMENTS IN ITALY

Mental health centres
699

Day-centres / Day hospitals
738

Services in General Hospitals	
Structures	Beds
320	4,084

Rehabilitation structures	
Rehabilitation	Beds
515	11,255

Consultation rooms
1,132

However, beyond these figures what is important is that the implementation of the psychiatric law, precisely because it was based on a process of deinstitutionalisation, is a social process (and not the linear, univocal enactment of a project). A social project involving many actors, goals, conflicts and contradictions. Or, to put it another way, the psychiatry of deinstitutionalisation has widened the field of institutionalised scientific uncertainties, and activated problems, contradictions and anomalies, also within other institutional settings and competencies.

By breaking the paradigm of problem/solution, the process of deinstitutionalisation also eliminated the possibility of a solution.

Dealing with the suffering and needs of persons in Italy opened the doors to a conflict which is not the conflict between the medical paradigm and the psychological or social paradigm, but between a 'linear, individualistic and non-historical' approach and an approach based on human development.

We can perhaps summarise in 10 points the practical characteristics of the path of deinstitutionalisation which we have followed until now, and which we consider to be the most suited to our aims:

1. The supremacy of practice. The dialectic between the (old and new) models and needs of patients, and the critique of ideologies which reformulate themselves continuously, oblige us to privilege a theory which tells us that the practice which concerns those needs is the only real means for acquiring knowledge of them.
2. The dialectic management/negation.
   We did not abandon the psychiatric hospital, we managed and transformed it, transformed and managed it until it became useless and superfluous. Today, we run services which we wanted to be strong in order to manage from a position of

strength the contractualisation between the city and ourselves, permitting us to refuse the self-referentiality of the services themselves.

3. Concrete exercise of the distrust of institutionalisation. We entered the general hospitals in order to contaminate medicine and in order to bring psychiatric management back into the general health care services, and not because we think that that is the place for 'admitting' madness.
4. Profound respect for differences.
   Even if mangled and thus often incongruous, differences indicate every day where the future may lie and what are the limits of the present.
5. Accepting risk.
   Interpersonal relationships (like that with the institution) to the extent that they incorporate the theme of freedoms and its obstacles, in individuals as well as in contexts, always imply placing ourselves at risk, and without risk emancipation is impossible.
6. Accepting conflict.
   Rules and institutions are changed only after practice, which enters into relations with them, reveal their anachronism.
7. The dualism exclusion-inclusion as the central issue and node of each process and each project.
8. The constant inter-connection between the specific issue (the illness, the patient, psychiatry) and more general issues (care, medicine, health, social policies and, why not? politics in general)
9. The concept of responsibility. The new involvement and activism of users and their families is an extremely important value. However, given that power ultimately always lies with the institutions, it is necessary to work for their democratisation.
10. Medicine's primary problem. 'One risks a new separation between the social and health which re-proposes the linkage of the complexity of variables (of different nature) present in what one tends to consider and treat only as the illness of a single individual. If one does not succeed in also having an impact on that variability, if the social does not penetrate into the heart of disciplines, and in particular into medicine, psychiatry will shut itself up and defends itself by means of pure technique, psychology will tend to mime the medical model and social assistance will direct itself towards the psychologisation of the problem, in re-proposing in every way discrete specialisations in which each practitioner is the master of their own sector.
    On the contrary, for us the safeguarding of health as a personal right has always been something which goes beyond specialisations which are based on the separation of needs and partial interventions. It is necessary to recompose the full range of elements which make up a life, both sick and healthy, to provide a constant and continuous integration of responses and the offer of opportunities'. Franca Basaglia.

Today, the fight against the social exclusion of vulnerable groups, which began with knocking down of the walls of psychiatric hospitals, continues in the attention for that 'nation with the little 'n', the nation of the excluded, which in our rich and 'developed' countries is reduced to silence and risks being (when it is not already) shut up and interned within new walls.

But with a human development approach, the question of the rights of citizenship (and the responsibility of professionals in the social-health sector to encourage and facilitate access to these rights) cannot be resolved by the creation of rigid pigeonholes for each group recently defined as vulnerable.

'The fight against social exclusion which we discovered in our experience in the asylum becomes likewise a criterion capable of producing great progress in the areas of Public Health Care, services for women and children, and services for the elderly' (L. Carrino).

Once again, the action of institutional transformation must develop through the synergies of intervention among the different sectors.

It is necessary to create ties, exchanges, breaches and networks, and work to keep both sides from trying to wall each other up alive.

Today, the situation of Italian psychiatry is still ambiguous. The procedures for a true inclusion are still weak. Economic, social, affective and public support is still largely insufficient. Inter-sectorial policies can be truly achieved only in certain areas of the country, and the biological and psychological regressions are immanent to this process.

Nonetheless, we believe that at the start of the new Millennium, Europe can, at the least, make the decision to do away with totalitarian institutions in psychiatry. It may not be much, but would still be of great importance.

Democracy is a condition which each day reveals its limits and difficulties that trouble us. But, at the very least, the end of totalitarian institutions should and must be demanded and achieved.

Our cities (perhaps moreso than our countries) need workshops for tolerance, places which nurture diversity, places for an 'urbane' culture. This is what the services are; these are the aims of the services of deinstitutionalisation.

They must become a great workshop of social tolerance, reproduction and emancipation. They must become the elements which constitute the city.

Over many years, we have built 24hr community mental health centres for each urban area of 50,000 inhabitants. The deinstitutionalisation of the city is constructed primarily through this type of service (and with other, lighter structures, described countless times in the literature). And we work to prevent the rebirth of psychiatric clinics and hospitals. This is the machinery of deinstitutionalisation. These are the pieces of the continuous and interminable restitution of madness to the city. Little by little, the city incorporates madness, and makes it its own. It no longer refuses madness, but reformulates itself with respect to it. It accepts it, takes it in.

This is the end of a century in which psychiatry was the servant of exclusion in cities.

Today, with the pressure of immigrants and the anthropological mutations produced by globalisation, the old exclusions are replaced by new emergencies. In front of the violence of our cities and the alienation of non-Europeans, the mentally ill lose their character of imaginary danger; after all 'they are like us, they are white, western and only a little bit strange'.

But psychiatrists must finally decide if they are always, and in every case, on the side of inclusion, if they are able to handle conflicts or must instead re-invent 'scientific' ways of legitimising exclusion.

Years ago, we chose to participate in the infinite patience of negotiations, which build the very essence of democracy. Whoever the citizens involved may be, because we are always and in every instance dealing with citizens. Each day, new social or ethnic groups get in the way of history and are dominated by history, but it is precisely there, on that dividing line, that that paltry thing called democracy (but which, ultimately, is the only 'good' we have) grows or dies a little. And therefore it is not without reason that a portion of Italian psychiatry wished to be defined with the adjective 'democratic'. This is not something which functions of its own accord. Not in Europe. Not in a Europe which until just recently had built Leros. Not in the Europe of Karadjic, not in the Europe of the tens of thousands of inmates in the psychiatric hospitals of the Federal Republic of Germany, not in the Europe where, during the wars of the last century, 200,000 inmates of psychiatric hospitals were killed outside of the combat zones.

The time has come, here, in Paris, in this new Century and far too long after the French Revolution, to finally salute the birth of a psychiatry of citizens, for citizens.