
Towards a holistic and humanist psychiatry – lessons from Italy

GLOBAL HEALTH

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This year, 40 years have passed since a total reform of Italian psychiatry took place. How has it progressed and what can we learn from it?



Marco Cavallo is a wooden sculpture made by patients and staff at the Manicomia di Trieste in 1973. It is modelled on a real horse that served at the hospital and was to be put down, but was saved when the patients demanded that it be allowed to stay at the hospital until it died of natural causes. The sculpture is intended to symbolise the freedom and dignity of those admitted to the hospital. Later, it became an emblem of the Basaglia Act. Photo: Davide Folloni, licensed under CC BY 2.0

In line with the recommendations from the World Health Organization (WHO), Norwegian psychiatric services have become increasingly decentralised over the last 20 years (1). Service provision at the district psychiatric centres (DPS) and in primary care units has been expanded, while the number of inpatient beds has been reduced, all according to the *Opptappingsplanen for psykisk helse [The escalation plan for mental health]* (1998–2008) (2). According to the Municipal Health Services Act, local healthcare services shall be responsible for prevention, care, rehabilitation and general treatment. The Specialist Health Services Act states that the specialist healthcare services shall restrict their services to examination and specialised treatment, and that the health care provided shall be cost-effective (3). The specialised mental healthcare services are striving to reduce the use of coercion, and there is a pressure on centralised wards. The places available are largely filled with patients who are either dangerous or sentenced to detention in a psychiatric institution. Those of us working in the public mental healthcare sector find that the district psychiatric centres are now under such pressure that they need to constantly cut down on

their activities. Instead of being a cornerstone of the patient treatment service, they are now merely a temporary stop on the way to the local treatment services. Despite the good intentions, collaborative meetings and individual plans, service provision has become more fragmented. The users have to relate to a large number of agencies. Our framework means that professionals spend an increasing amount of time on administration and less time on providing flexible services to users. In this landscape, perhaps we could do with some inspiration from other countries that have addressed these challenges differently? We went on a study trip to Italy, the country that inspired the World Health Organization to go for a more decentralised and humane psychiatry. Do we still have something to learn?

The Basaglia Act

Psychiatry in Italy in the 1950s was generally based on large asylums. Considerable undocumented coercion was used, the patients were often kept sedated and had few or no rights. The asylums mainly served as depositories and were reminiscent of prisons (4). This was the starting point for the movement that championed a democratic and humane psychiatry, led by the charismatic, revolutionary psychiatrist Franco Basaglia (1924–80). In the 1960s, there was much focus on 'the therapeutic society', but Basaglia also strove to open up the Italian asylums and eventually close them down. The struggle ended in a psychiatric reform, Act 180 of 1978, also known as the Basaglia Act. It stipulated that all state-run psychiatric institutions should be closed down and replaced by local mental healthcare centres. Patients should be treated in their own local community on a voluntary basis. A psychosocial approach should lead to meaning, freedom and integration into society (5).

In the model that emerged, each health region had a local department of psychiatry with a number of local psychiatric centres, rehabilitation beds and an emergency psychiatric ward in the local hospital. The local psychiatric centres were the hub for all treatment and should stay open at all hours, and no referral should be needed to contact them. The centres had some beds at their disposal and were to provide interdisciplinary treatment with a holistic focus. When coercion had to be used, only the treatment criterion applied, and in the case of patients who were dangerous, the judicial system became involved (5, 6).

Now that the Act is celebrating its 40th anniversary, there is a lively debate in Italy about the psychiatric services. Many claim that these services are inadequate and that a major new movement is required in order to reawaken the engagement and develop Italian psychiatry (4). Italian psychiatric services vary considerably from one region to another: the health regions are independent, and operate their services differently. The amount of money spent on the psychiatric department in each health region varies from 2.1 % to 6.5 % of the region's total health budget. Total spending on mental health currently amounts to 3.5 % of the total health budget (6). Especially in Northern Italy, the Act appears to function as intended. Little coercion is used, and there is

little need for beds in centralised institutions. Trieste is a case in point. In other parts of Italy, where local service provision has been reduced, more coercion is used (6).

On a visit to Trieste

Earlier this year, five professionals who all work in psychiatric services in Oslo went on a study trip to Trieste. En route, two of us went to Rome, which we have also visited on previous study tours. Our colleagues there outlined a negative picture of Italian psychiatry. The centres lack the resources necessary to stay open 24 hours, and they are unable to help all those who need it. The shortage of resources was partly explained by the financial crisis in Italy, but also partly by the outflow of considerable funds from psychiatry to private clinics and nursing homes.

Until recently, Italy had a separate forensic and security psychiatry that dealt with those who were considered dangerous and could be sentenced to detention in a mental institution. In 2015, security psychiatry was relocated from the Ministry of Justice to the Ministry of Health. We were told that patients who are dangerous or sentenced to psychiatric treatment are now detained in small, reinforced, secure psychiatric units that focus on therapy, social psychiatry and rehabilitation.

From there, we continued to Trieste. Our programme was arranged by the World Health Organization's Collaboration Centre for Research and Training there, and we were taken on a visit to a number of different psychiatric services. The director of the mental health administration in Trieste, Roberto Mezzina, claimed that there was close to no use of coercion, few admissions and virtually no acting-out in their local setting. The Greater Trieste region has approximately 240 000 inhabitants and four local psychiatric centres with six beds in each. Each centre has a catchment area of 60 000 inhabitants. In the whole of Trieste, there are no more than six emergency psychiatric beds.

In Norway, dangerous and demanding patients fill the beds in central institutions. Where are such patients in Trieste? We were told that since focus is placed on human rights and the freedom of the individual, this freedom comes with a responsibility. The majority of criminals are in prison, and the local psychiatric centre provides follow-up as required. During our visit, the forensic psychiatry unit in Trieste was empty. Those who had been referred there had completed their treatment and been rehabilitated back into society.

The work cooperatives play a key part in the treatment and rehabilitation of patients, who are actively engaged in meaningful activities, with a focus on individual adaptation here as well. The cooperatives are intended to be useful and competitive. The authorities make provisions for work grants and social grants, and enterprises that hire persons with reduced functional capacity are exempt from paying employer social security contributions.

At Barcola, the local psychiatric centre, we heard about a flexible approach that puts the patient's project at its centre. If the users' condition worsens and they reject help, they are not abandoned: 'The users have the right to walk out, but we have the right to go after them'. If an ill person refuses to receive treatment, the staff continues to show concern, seek him or her out and offer flexible solutions. This involves some negotiation and requires great patience. Much of the activity is ambulatory, and approximately 100 users call into the centre every day for group therapy, conversation or practical help, or to participate in self-managed user groups. We were told that two-thirds of the users have psychosis-type disorders, but it was emphasised that services and interventions were decided on the basis of functions and needs, not just the diagnosis. Drugs were administered in accordance with international guidelines and with the aim of providing the smallest possible effective dose. Therapies are holistic, with the primary emphasis on relationships, the patient's project and continuity. Our impression concurs with the findings in a Dutch study of service provision in Trieste (7).

Stays in the emergency psychiatry ward are kept as short as possible, often just to a single night. Patients tend to arrive when crises occur in the evening and night time. The goal is to achieve that the treatment is voluntary and to bring the patients out to the centre as quickly as possible. If patients need to be admitted to the emergency ward, a therapist from the centre provides follow-up during the admission period.

The social services engage in extensive outreach activities, voluntary work on activities and distribution of food. References were made to Basaglia, human dignity, freedom, flexibility and integration into society. The healthcare and social workers appeared to be genuinely engaged in the users' situation and were willing to go to great lengths to help them. They talked warmly about their collaboration partners. We were struck by a system where everybody seemed to pull in the same direction. The people of Trieste are said to be more reserved and sceptical than other Italians, so it was claimed that the success in Trieste has come in spite of a closed and sceptical culture.

In Trieste, there are reportedly no private clinics and nursing homes. Patients with addiction disorders in addition to mental disorders are treated in separate programmes for drug-related care. Psychiatric services provide guidance as needed. Patients with minor mental disorders are treated by their GP, occasionally by a psychologist or psychiatrist in private practice.

Are there lessons to be learned?

It is difficult to compare systems and realities that exist in countries with different socioeconomic structures, demography and cultures. We nevertheless believe that we can learn a lot from Italian psychiatry. We could clearly see how vulnerable this system is to disruptions of its cornerstone elements. Insufficient application of resources at the local psychiatric centres will make it difficult to achieve the continuity and availability needed to prevent the patients' condition from worsening. Establishing an appropriate voluntary treatment programme

in cases of relapse requires time and flexibility. Alternatively, the result will be an accumulation of patients who need a higher level of care and more coercive measures. In Italy, the money largely follows the patients. Wherever private clinics are used, less money will be left in the public services. We were told that in a number of places in Italy, this has caused the mental healthcare services to function poorly, without the regions necessarily spending less money overall.

The key seems to be holistic treatment, availability, flexibility and continuity. By holistic treatment we also mean prevention, care and rehabilitation. In the treatment of the patients with the severest disorders, such a distinction is artificial. In Norway this appears to lead to overlapping and inadequate services and to an unnecessary fragmentation of treatment. Continuity and availability at the psychiatric centres must be regarded as a key element of prevention. The therapist and the centre follow the patient wherever he or she may be, at home or in prison, it makes no difference.

Here in Norway we also want to be flexible, but it is difficult to meet the patient out in the community and maintain patience in the face of time constraints and long waiting lists. There is talk about seamless transitions and close collaboration, but in day-to-day activities we constantly need to set limits. In the specialist healthcare services we need to assess rights, restrict, discharge patients prematurely – often to quite scanty municipal services. The local services are charged with provision of care, prevention, rehabilitation and general treatment. In addition, guidelines stipulate that they should provide services at the lowest possible level. We have experience from different Oslo districts that are extremely bound by rules and decisions, leaving little room for availability and flexibility. Patients often fall between two stools. In recent years, the authorities have adopted a number of measures intended to ensure user rights. In practice, we feel that these often restrict the opportunities for individual adaptation. However, as a service for those with the severest disorders, a number of flexible assertive community treatment (FACT) teams have been established in collaboration between the specialist and municipal healthcare services.

Our impression is that in Norway there is more specialised treatment, more psychologists and more psychotherapy in the public sector (although requirements for efficiency are gradually reducing service provision) and better inpatient departments than in Italy, and we would like to maintain this advantage. But could psychiatric services be optimised by reintegrating some of the tasks that have been delegated to the primary healthcare services? Or could the specialist and municipal healthcare services through joint funding succeed in establishing more co-located, local psychiatric centres, in the same vein as the flexible ambulatory teams, but with better availability?

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