Community psychiatry without mental hospitals – the Italian experience: a review

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Mental hospitals and community psychiatry: problems of definition

The WHO Working Group report on *The Future of Mental Hospitals*[1] states that 'there is no definition of a mental hospital'. The participants to that Working Group concluded that, since it is impossible to define a mental hospital using criteria such as its size or the characteristics of the patient population, which varies from hospital to hospital, probably the most satisfactory definition would be a modification of that given for a specialized hospital in the Regional Office for Europe's *Glossary of Health Care Terminology*[2]: 'A mental hospital is a hospital admitting primarily patients suffering from mental disorder, where clinical and administrative responsibility rests predominantly or exclusively with psychiatrists.'

We can probably have a better and clearer idea of what in fact a mental hospital is, if we try to describe the way these institutions function and the role that the 'average mental hospital' has had, and still has, in many western countries. Franco Basaglia, a leading Italian psychiatrist who inspired and was the architect of the Italian psychiatric reform, wrote in 1971[3]: 'The *manicomio* is a deposit where people believe the mad (*i pazzi*) are sent, where intellectuals believe the lunatics (*i folli*) are sent and where doctors believe mental patients are looked after and treated. For the mad, the lunatic and the mental patient it is a locked, oppressive and total institution where punitive, prison-like rules are applied, in order to slowly eliminate its own contents. In the *manicomio* doctors, nurses and patients are all subjected (at different levels) to the same process of institutionalism. Its role is to explicitly isolate and control socially disturbing subjects, the illness being only a very marginal element.'

One could argue that Basaglia was referring to the situation of mental hospitals in Italy, while most of these institutions in other western countries, including England, were already collections of hostels and sheltered workshops, far from being cut off from their communities, encouraging unrestricted visiting as well as arranging for many patients to work outside the hospital. However, such a model of the 'best mental hospital'[4] was probably rather rare also in England at the time Basaglia wrote his definition, as may be inferred from a report of the Royal College of Psychiatrists[5]. This states: 'In the average mental hospital, a long-stay patient is likely to see a doctor for only ten minutes or so every three months. Even a recently admitted patient is seen by a doctor for an average of only 20 minutes each week. Scandals about the ill-treatment of patients in mental hospitals, including those of relatively good reputation, occur with monotonous regularity.' Professor Anthony Clare[6], discussing the subject a few years later, declared that 'such conditions can still be found in many psychiatric hospitals at the present time'.

In the last decades a shift from hospital-centred to community-based psychiatry has been observed in many western countries. It is well known that in the United Kingdom it began in 1930, with the Mental Treatment Act. Even the formulation of a definition of 'community psychiatry' appears to be a difficult task. Various definitions of community psychiatry may be found in the literature. Bennett[7] expressed the view that 'according to Sabshin[8], it is possible to reformulate community psychiatry as a use of the techniques, methods and theories of social psychiatry, as well as those of the other behavioural sciences, to investigate and treat the mental health needs of a functionally or geographically defined population over a significant period of time. According to this formulation, community psychiatry is concerned with the mental health needs not only of the individual patient but of the district population; not only of those who are defined as sick, but those who may be contributing to that sickness and whose health or well-being may, in turn, be put at risk.' Serban[9], on the other hand, describes community psychiatry as having three aspects: first, a social movement; secondly, a service delivery strategy, emphasizing the accessibility of services and acceptance of responsibility of the mental health needs of a total population; and thirdly, provision of the best possible clinical care, with emphasis on the major psychiatric disorders and on treatment outside total institutions. A definition of community psychiatry I would like to propose is: 'A system of care devoted to a defined population and based on a comprehensive and integrated mental health service, which includes outpatient facilities, day and residential training centres, residential accommodation in hostels, sheltered workshops and inpatient units in general hospitals and which ensures with multidisciplinary team work, early diagnosis, prompt treatment, continuity of care, social support and a close liaison with other medical and social community services and, in particular, with general practitioners.'

The aim of community care is to reverse the long-accepted practice of isolating mental patients in large institutions, to promote their integration in the community offering them an environment that is socially stimulating, while avoiding exposing them to too great social pressures. There is evidence to show that merely transferring patients from hospital to the community is not of itself sufficient to improve the quality of their life[10]. It has also been suggested that it is the features of the care, and not where that

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care is provided, that determine the patient's quality of life. However, as those in favour of community psychiatry stress, the hospital is *not* a natural social environment. Hospital-based treatment therefore cannot provide the full range of opportunities which enable the patient to acquire confidence and self-esteem through success in social roles. On the contrary, hospitals are often places where an excessive emphasis on physical treatments continue to be placed. Moreover, as Bennett[7] stated, 'only working in the community it is possible to tackle a person's difficulties in the first instance in the place where they occur'. This possibility has many advantages and offers useful therapeutic opportunities. Critical views on the 'myth of community care' have also appeared[11].

All three aspects of community psychiatry described by Serban[9] may be found in the Italian experience, the first being a particularly important ingredient. The criticism of the mental hospital and of the old-fashioned, restrictive and custodial way of treating psychiatric patients based more on 'confinement' than therapy, which took place in Italy starting in the early 1960s and which involved a large part of the population as well as professionals in the field, may be properly understood only if one considers that it was part of a general 'social movement'. This movement was very much connected with students' and women's organizations, and with trade unions. It aimed to combat the 'total institutions', promoting health as a 'right for all', including the poor and the neglected. From this point of view it is true that, as Basaglia said[12], 'The Italian experience is in one sense unique ... and can therefore hardly serve as a model in other social circumstances.' I am not aware of any other experience in other countries where the problem of psychiatry and psychiatric services has been so widely discussed outside professional circles, attracting public interest and concern. One of the effects of this situation has been that, in Italy, the campaign to change the old system of psychiatric care was 'a public rather than a specifically professional campaign. It is difficult to imagine similar public concern in Britain'[13].

Italian psychiatric reform

In May 1978 a psychiatric reform (Law 180) was passed by the Italian Parliament, and in December of that year became part of the National Health Reform (Law 833) that introduced the National Health Service in Italy. The main features of the Italian reform have been reported elsewhere[13-15]. The reform aimed gradually to dismantle the mental hospitals and called for a comprehensive, integrated and responsible community mental health service.

One important aspect of the Italian model of 'community psychiatry' is that the phasing out of the mental hospital is being achieved gradually through a block on first admissions (which came into effect in May 1978) and subsequently on all admissions (since January 1982). It is therefore a very different model from the American community mental health experience, where an abrupt deinstitutionalization occurred[16]. It is also different from other models of community care set up in places where admissions to the mental hospital are still possible, and under which circumstances the community services 'work merely because only the cases they are likely to succeed with get sent to then, and this is only possible as long as the asylum is in the back-ground as a repository for intractable suffering'[17].

Another important aspect of the Italian model is that hospital psychiatry is considered complementary to community care and not vice versa. It is important to point out that the new Italian law was created following long-term pilot experiences of deinstitutionalization that took place in several cities (including Gorizia, Arezzo, Trieste, Perugia, Ferrara) between 1961 and 1978. These pilot experiences were able to demonstrate that it was possible to replace old-fashioned custodial care in mental hospitals with alternative community care. This demonstration consisted in showing the efficacy of the new system of care in terms of its ability to make a gradual and definitive closure of mental hospitals possible, while the new services, which can appropriately be called 'alternative' instead of 'complementary' to the mental hospitals, were being set up. These services include group homes, supervised hostels and unstaffed apartments, as well as day centres and cooperatives run by patients. However, standardized data collection and epidemiological evaluative studies have been few, and there has for some years now been a need to evaluate anew what has been and is being done.

National statistics on mental hospital activity and on completed suicides, before and after the psychiatric reform

The data presented here are taken from two studies carried out in cooperation with Dr Paul Williams, from the Institute of Psychiatry, London (during his appointment as visiting Professor of Psychological Medicine at the University of Verona), and Dr Domenico De Salvia, from the Dipartimento di Psichiatria, Portogruaro (Venezia). First, we thought it would be interesting to face the issue of the extent of mental hospital closure in Italy, after the psychiatric reform. The necessary information is provided by national statistics, which are published annually by the Central Institute of Statistics (ISTAT) in Rome[13].

With regard to the indices of mental hospital activity, the 23-year period from 1960 to 1983 can be divided into three sections. The first, prior to the 1968 legislation, was characterized by relatively stable bed numbers (a maximum of 1.73 beds per 1000 population in 1963, with an average decrease of 1390 beds per year since) but by an increasing number of admissions. Thus, the mental hospitals were starting to function as true hospitals; that is, a revolving door policy was starting to operate, rather than simply providing custodial care on a long-term basis.

Law 481 ('the Mariotti reform') was passed in 1968. Its major provisions were that voluntary admissions to mental hospitals became possible, outpatient clinics (*Servizi di Igiene Mentale*) were set up in the community – being primarily concerned with the follow-up of former mental hospital patients – and the size of the mental hospitals was reduced (a maximum of 625 beds per hospital). During the second period – between the Mariotti reform and Law 180 – the number of mental hospital beds and consequently the number of resident patients diminished precipitously (with an average decrease of 3305 beds per year), while the number of admissions continued to increase until 1975. During the third period (since the 1978 reform) bed numbers and residents dimin-

ished at an accelerating rate, while no patients have been admitted to mental hospitals since the end of 1981. In 1983 there were in Italy 0.76 mental hospital beds per 1000 population. Thus, it is quite clear that the 1978 reform formalized and legalized a pre-existing trend of deinstitutionalization, a trend which is common to most European countries and which is consistent with World Health Organization policy[1,18-21]. In our study[13] we also showed that the number of private psychiatric hospital beds decreased by 7% and the number of residents by 12% during the three post-reform years (1979–1981) for which data are currently available. Admissions to these private hospitals reached a maximum in 1977, just prior to the reform, and have remained relatively stable since.

In another study[22] we adopted an ecological approach to evaluate the effect on suicide of the Italian psychiatric reform. In order to test the hypothesis that the widespread reduction in the numbers of mental hospital beds might result in an increase in the suicide rate we used regional data, comparing the trend in suicide during the pre-reform quinquennium (1973–1977) with that during the post-reform quinquennium (1979–1983). The results show that the suicide rate in Italy has as a whole increased consistently over the past 10 years, this increase being largely confined to the north/central part of the country. No clear time trend emerged with respect to the proportion of suicides classified as being due to mental illness (Figure 1). The difference between the two five-year trends (1973–1977 *v.* 1979–1983) was positive (i.e. an increase in the suicide rate) for 10 of the 19 regions in Italy. This difference was negatively correlated with the provision of general hospital psychiatric beds, a finding which persisted when the pre-reform trend in suicide was controlled for. The post-reform regional provision of mental hospital beds (which have diminished considerably in recent years) was not related to changes in the suicide rate. This study stresses the usefulness of comparing trends in rates, rather than averaged rates, in the investigation of the effect of a new service on suicide.

It is well known that the psychiatric reform has not been uniformly applied throughout the country, because of the Italian economic situation, political opposition in the most traditional regions and opposition from traditionally trained psychiatrists and other mental health professionals who have difficulty in modifying their practice according to the community-oriented model[13]. In regions where standards of psychiatric care are unsatisfactory, the most common feature is the lack or insufficient development of community-based programmes. On the other hand, there are regions and districts where the psychiatric reform has been actually implemented and the standards are acceptable[23].

An evaluation of the 'quality' of the Italian psychiatric reform is therefore only possible in areas where the reform has been fully implemented and comprehensive community services have been organized and integrated thoroughly[24], this in order to distinguish between failure to implement the reform and failure of the reform itself, a distinction that some outside observers have failed to make[25] (*see* Appendix). Case register data from such areas are available and may be used to describe and evaluate some aspects of the post-reform psychiatric care.

Patterns of psychiatric care in three case register areas

The three best established Italian psychiatric case registers are operating in Lomest (in Lombardia), South-Verona and in Portogruaro (both in Veneto), although data are also being collected in other areas of Northern Italy[26]. No functioning case registers exist in southern Italy. Only the Lomest register started before the psychiatric reform (on 31.12.75), while the South-Verona register began operating on 31.12.78[27] and the Portogruaro register on 31.12.81[28]. All three are modelled on the Camberwell case register[29] and cover areas of 75 000–90 000 inhabitants) where community psychiatric services have been set up and organized according to the provisions of the new law. The services in these areas provide both inpatient care (in 15-bed units in general hospitals) as well as outpatient and community care[30-33]. Mental hospitals are situated 18 miles from Lomest and 9 and 45 miles from South-Verona and Portogruaro respectively. Our data[13] show that in each of these three areas, most of the patients are treated outside the hospital only (not-IP), the highest not-IP rates being found in South-Verona (where they have been increasing over the last 5 years, probably in relation to the development of the community services), while the rates in Lomest and Portogruaro are similar to each other. The rates of patients in hospital on census day or admitted at least once during the following

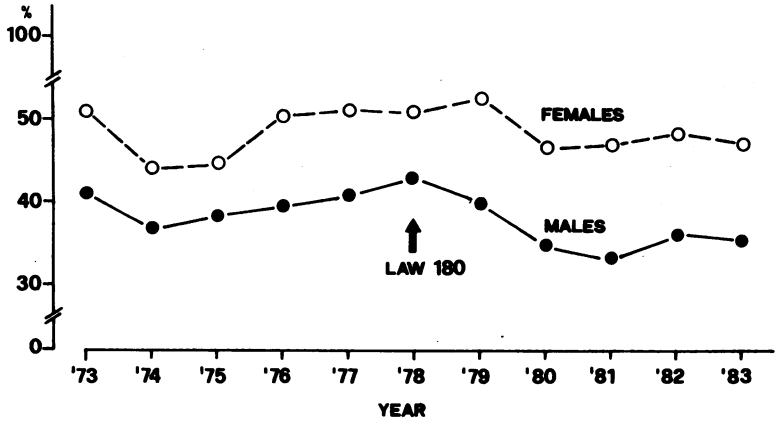

Figure 1. Proportions of suicides attributed to psychiatric illness before and after the Italian psychiatric reform (data taken from Williams et al.[22])

Table 1. Patients receiving outpatient care only (not-IP), or receiving both in- and outpatient care only (IP) in 3 case-register areas. Rates per 1000 adult population (data from Tansella et al.[13]*)*

		1979	*1980*	*1981*	*1982*	*1983*	*1984*
Lomest	Not-IP	5.82	6.63	6.50	5.97	6.25	—
	IP	1.85	1.60	1.49	1.54	1.59	—
	Not-IP/IP	3.1	4.1	4.4	3.9	3.9	—
Portogruaro	Not-IP	—	—	—	6.17	5.97	6.78
	IP	—	—	—	0.89	1.15	1.25
	Not-IP/IP	—	—	—	6.9	5.2	5.4
South-Verona●	Not-IP	6.45	7.30	7.13	7.56	8.42	9.03
	IP	3.58	3.13	2.40	3.49	3.78	3.44
	Not-IP/IP	1.8	2.3	2.9	2.2	2.2	2.6

● Admissions to private in-patient services and, since 1982, to neurological wards (with a psychiatric diagnosis) are included.

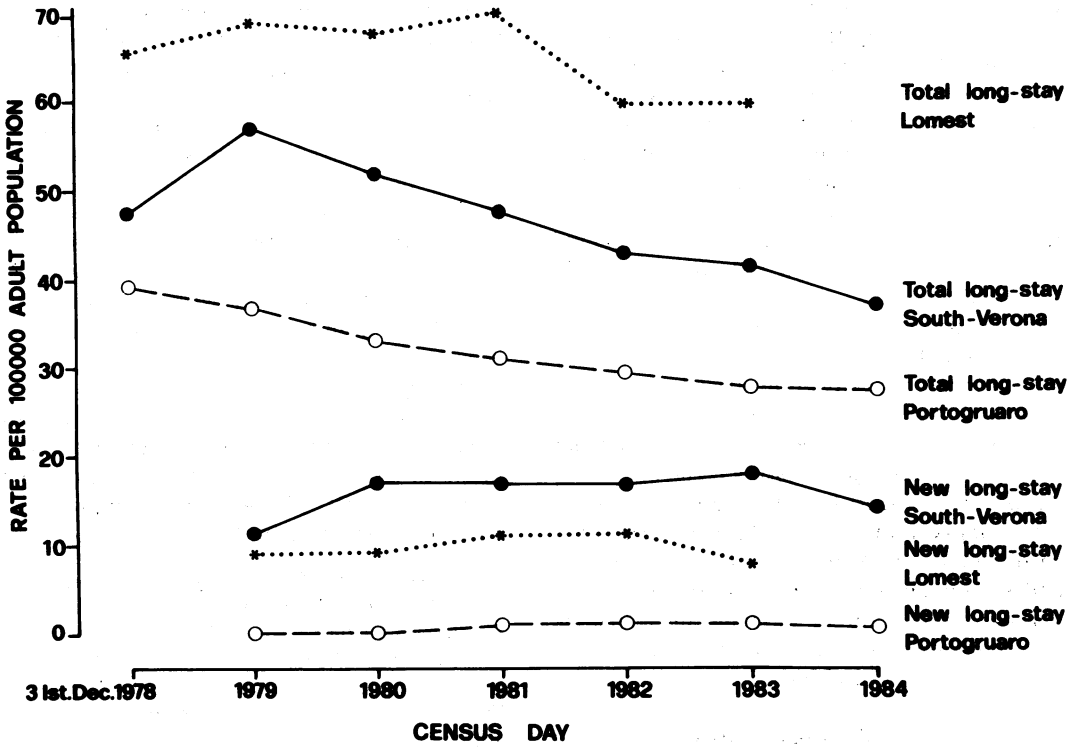

Figure 2. Total and new long-stay inpatients in three Italian case register areas: Lomest, South-Verona and Portogruaro (from Tansella et al.[13]*)*

year (IP) are also higher in South-Verona, where more beds are available.

The most recent not-IP/IP ratios are 2.6, 3.9 and 5.4 for South-Verona, Lomest and Portogruaro respectively (Table 1). These ratios confirm the community orientation of the three services in Italy.

The proportion of inpatients accounted for by long-stay patients (i.e. those in hospital on census day and who have been hospitalized for one year or more) differs between the three case register areas. Figure 2 shows the long-stay rates for seven census days, 1978–1984. It can be seen that higher rates are found in Lomest than in South-Verona or Portogruaro, but that they have been decreasing over the years in all three areas. Rates of new long-stay (i.e. patients who were not long-stay on the original census day but have become so since)[34] can be seen to be very low (approaching zero in Portogruano), and there is no evidence that such patients are accumulating in any of the three areas.

Data on hospital admissions, days in the community mental health centres and outpatient contacts in Portogruaro and South-Verona during 1982–1984, show that while admission rates have remained low, day and outpatient contacts (the latter including home visits made by all staff) have substantially increased in both areas. Moreover, in South-Verona and Portogruaro, compulsory admissions to hospital (*Trattamenti Sanitari Obbligatori* – TSO) have decreased substantially since the psychiatric reform, certainly by comparison with the 1977 rate[13].

Conclusions

Most psychiatrists would agree that both community and hospital care are necessary components of any system of psychiatric care prepared to meet the needs of various patients. The point is that in most cases inpatient treatment is considered to be the principal component of the system and com-

munity care is regarded, and often also called, 'complementary'. The other way round is quite rare. If we liken the process of planning psychiatric services to the procedure for preparing a cocktail, we may consider the following elements: (1) we have to decide which is going to be the principal or 'basic' component; (2) we must choose the right doses of the different components and also the right ratio between the doses, bearing in mind that if, for example, we put too much gin into the cocktail, we also affect the taste and the flavour of the other components; (3) we have to pay great attention to the 'shaking phase' (or the integration between the various facilities within the system of care, to ensure continuity of care and to avoid overlapping).

The main characteristics of the Italian experience or, if you prefer, the recipe that we found appropriate for our country, are: community care as the principal component of the system (what we call 'community priority'); a relatively low dose of inpatient care, avoiding treating any new patients in mental hospital (which we consider to be antitherapeutic and toxic even at low doses); a very careful 'shaking', or a very careful integration between the various facilities within the geographically-based system of care, the same team providing outpatient as well as inpatient and community care. Hospital admission is, of course, still considered necessary for some; but, as Law 180 states, it should not be the first resort.

I have presented here some data on the basis of which it is possible to understand, albeit in a preliminary way, what is really going on in our country. The national data have confirmed that, as far as mental hospital beds are concerned, the Italian reform is accelerating a pre-existing trend of deinstitutionalization. The shift from the public to the private system of psychiatric care, which was predicted by some, did not occur. Moreover, national statistics on suicides have shown no increase in the last 10 years in the proportion of suicides classified as being due to mental illness and no relation between decrease in mental hospital beds and changes in the suicide rate.

In evaluating the Italian psychiatric reform, the most interesting results from the psychiatric case registers will probably emerge when it will be possible to examine trends over a sufficiently long period of time. The data reported in this paper give an example of psychiatric care provided after the reform in three case register areas in Northern Italy and may allow preliminary international comparisons. One of the most striking results is the low inpatient rate found in all three areas; moreover, long-stay inpatients, whose numbers were already considerably low before 1978, are still slightly decreasing in number. Another result which deserves comment is that in all three areas most of the patients are in fact treated outside the hospital, as indicated by the Italian psychiatric Law.

A study has recently been completed in South-Verona on high users and long-term users of mental health services. Patients who are both high and long-term users and are actually treated in the community (most of them living with their family) seem to have similar characteristics to those who before 1978 were admitted to mental hospitals and became long-stay patients. Moreover, using a log-linear analysis, a strong association between the pattern of service use and diagnosis, occupational status and previous psychiatric contacts was found[41]. Further studies are necessary to evaluate qualitative aspects of the care offered and its outcome.

It also appears that appropriate action must be taken to ensure a national homogeneity in the implementation of the psychiatric reform and in the development of community services. It is necessary to remember that there are many places (especially in southern Italy) where the reform has not been implemented and is obviously not functioning. There are places where community services have not been built up to an adequate level. The Ministry of Health should provide rather detailed instructions to regional and local governments and to health authorities for setting up community services, as well as sanctions for non-compliance. The methods of community care, and the steps which must be taken to develop these services, need to be made explicit. Moreover, at a national as well as local level, the ways in which the community-care programmes should be evaluated must be specified, and the evaluation should always be an integral part of the programme.

The situation as a whole is now contradictory. It has to be admitted that, in spite of the satisfactory results obtained in many areas, the new mental health policy in Italy has been neglected by politicians and administrators in the last few years, after the approval of Law 180. It is now urgent that this trend be reversed, with mental health care placed in a higher rank in the hierarchy of medical specialties.

I would like to conclude by quoting the words of Antonio Gramsci, a leading Italian politician and a famous writer: 'In order to change for the better one needs to balance the pessimism of reason with the optimism of will.' There is still a long way to go, but we feel we are going in the right direction.

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APPENDIX

The paper by Jones and Poletti[25] on the Italian psychiatric reform, entitled 'Understanding the Italian experience', is a superficial and unbalanced report of a journey to Italy, perfused with an old-fashioned and unrealistic colonial attitude. I have previously commented on this paper in a letter to the *British Journal of Psychiatry*[36], but would like here to make a few additional comments.

It is surprising to note how two visitors from outside, who have no clinical experience, claim to have understood after a few days of travelling around, not only the present situation of psychiatric care in Italy but also the social and political background of the Italian reform. The pretension of 'understanding' of these two authors who, as noted by Walsh[37], 'at times lose their objectivity', contrasts with the many errors which may be found in their paper. For example, the definitions they try to give of *Gattopardismo* and *Pluralismo* (p 343) are wrong. They have not been well informed nor have they realized that the former expression simply refers to the practice of making cosmetic alterations as a means of avoiding radical or basic changes. Moreover, they say that there is no exact equivalent of the concept of *Pluralismo* in English and claim that it is one of the 'dis-

tinctive concepts that Italy has of its own' (p 343). In fact, the concept is not Italian and has been discussed extensively, together with its economic implications, by Harold Laski as well as by some French authors, i.e. Hauriou and Duguit. Last but not least, the political party that they claim is the successor of the Fascist Party, the *Movimento Socialista Italiano*, does not exist. It is difficult to understand how one can confuse the 'Italian Socialist Party' (*Partito Socialista Italiano*) with the right-wing 'Italian Social Movement' (*Movimento Sociale Italiano*). Fortunately, there are more objective published accounts of what could be and in fact has been achieved under the Italian reform[38-41].

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