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1978-2018. The Basaglia Law forty years after

Mario Augusto Maieron
ASL Varese (now Agenzia di Tutela della Salute – ATS - dell'Insubria)

Abstract. Forty years after the Law 180 gives the author an opportunity to speak about the changes brought about in psychiatry since 1978 and to assess psychiatry today, in its organisation, expertise, epistemological references, clinical expressions and operative methods in addition to its critical issues.

Key words: Law 180, Franco Basaglia, psychiatric renewal, reorganisation of Mental Health Services, sector psychiatry, community psychiatry, residential psychiatry

The Law 180, known as the Basaglia Law, is forty years old.

It is the law that sanctioned the closing of mental asylums, the conclusion of a period, defined by Edoardo Balduzzi as "the years of Italian psychiatry", that go from 1964 to 1978 (1), in which the reform movement was developed and completely modified the prerequisites of care and assistance for persons with psychic disturbances that were put into practice in the years to come.

Alberta Basaglia, psychologist and vice president of the Basaglia Foundation, remembering her father in one of the numerous interviews granted on this occasion, underlined his great merit, besides the organizational aspects of psychiatry, was that of restoring dignity to those who had been marginalized and excluded.

Franco Basaglia who, in the Padua University Clinic where he had initially worked, was known as "the philosopher", had his cultural roots in phenomenology and more specifically in the anthropophenomenology of Ludwig Binswanger (and in Italy that of Danilo Cargnello). They considered mental disturbances, apart from the health-illness antinomies, as aspects of human presence, creating the prerequisites for a radical change in the methods of their confrontation compared to the where and how that positivistic medicine, born at the end of the 18th century, had confined them, and earlier still, as remembered by Michel Foucault, placed them as diseases of the soul, fruit of insane passions, in the category of vices (2).

Not only Binswanger however.

Other phenomenologists such as Edmund Husserl, with his epoché, Martin Heidegger between phenomenology and existentialism, Eugène Minkowski with his ideas of time, of Bergsonian derivation and lived time and Jean Paul Sartre with *Being and Nothingness,* had influenced his thoughts. His merit, however, lies not only in his original re-elaborations of philosophic conceptualizations, but also in having brought concreteness from a practical point of view to his ideas concerning his experiences above all in Gorizia and Trieste and his battle against the mental asylum which, during the Seventies of the last century together with MAI (the Anti Institutional Movement), had become the dominating theme of the reform movement expressed by official psychiatry and its associations.

This is perfectly summed up in the conclusion given in Wikipedia on his thoughts and way of conducting psychiatry

> […] keep listening and divest yourself of every certainty, […] make a suspension, an epochè, of all the sclerotic categories, in order to let the patient have his say (3).

The Law 180 represented the conclusion of his battles, it was not, however, his law, even though he accepted to give it his name.

In parliamentary circles it was a preview of a law then under discussion in National Health Service institutions that also included psychiatry. This had been promoted by the psychiatrist Bruno Orsini, a Demo Christian M.P. to avoid holding a referendum proposed by the Radicals for the repeal of the 1904 law on mental hospitals that, if rejected, would have proved a disaster for the reform projects that would have been difficult to remediate. It was in fact a compromise between those (SIP – Italian Society of Psychiatry – and AMOPI – Association of Italian Psychiatric Hospital Doctors-) who intended to eliminate the psychiatric hospitals by setting upwards inside General hospitals and those (MAI – Anit-Institution Movement – Democratic Psychiatry) who retained even these were unnecessary (4).

The law, as far as the closure of asylums was concerned, coincided with the ideas of Basaglia. He retained, however, that placing psychiatry inside hospitals and the same National Health Service was somewhat mystifying, because it tended to reattribute psychiatric suffering to illness, in a naturalist and positivistic sense, negating the work accomplished to give it a social dimension, both in an anthropological and sociogenetic sense.

This has been expertly documented in *Conversations concerning the Law 180,* that Basaglia published in 1980 not long before his death (5).

The 180, however, although giving only very limited indications on psychiatric reorganization, brought to an end not only a period of certain treatment methods for persons with serious psychic disturbances but, compared to the 1904 Law, it completely modified the approach and herewith lies its revolutionary character.

In fact, the 1904 Law, for involuntary commitment, dealt primarily with the social problem of "dangerous to oneself and others" and "public scandal". Hospitalization, temporary for the first thirty days, for the purpose of checking the mental disturbances, cause of behavioural disorders and their persistence, and the "definitive commitment" were not the responsibility of the patient's psychiatrist but of a judge who gave authorization with a sentence issued in the Council Chamber, which also involved loss of civil rights and registration in a special judicial register. The sentence could be modified only by another sentence and the problem of the treatment was secondary. It had become relevant for the progress in the therapies made for some disturbances above all from the Twenties onwards, but it only had an effect on legislation with the Law 431 in 1968 that allowed for voluntary hospitalization "for findings and treatment" without the legal effects that were in act for authorized admissions.

The 180 instead cancelled all the legislations set out in the 1904 Law and always considered the psychic disturbance as a problem of the person, while laying down certain principles of reference for the treatment.

The subject on the findings and the compulsory health treatments with ample guarantees on times and methods for the persons involved (six articles) was explained in greater detail.

Other matters concern hospital psychiatry, with the creation of *Psychiatric Services for Diagnosis and Treatment (SPDC)* in general hospitals which were equipped with a very limited number of beds, intended to manage only extremely critical situations, regarded as coordinated and integrated with territorial Psychiatric Services and Mental Hygiene that were, however only generically indicated. Competence for the organization of the entire sector, which up to then had come under the auspices of the Provinces, on the basis of the 1865 Law, made just after the Unification of Italy, was assigned to the Regions. The final articles refer, as mentioned, to the repeal of the 1904 Law, some articles of the Penal and Civil Code and the law on active and passive voting rights, indications on a transitory phase for patients in psychiatric hospitals and on the expertise of the psychiatrists and their various qualifications.

Apart from considerations on the law itself, speaking about the 180 forty years after its enactment signifies above all talking about how the change in psychiatry has taken place and what psychiatry is like today, not only its organisation, that is affected by several regional legislations, but also its skills, its doctrinal references, its clinical expressions and ways of working. It signifies speaking about those persistent criticisms and precariousness and how, in recent years, society has changed, in its culture, symbolic expressions, its reference values and how this has effected not only the

behaviour of persons but also the ways of expressing their conditions of malaise.

As far as the organisation of Psychiatric Services is concerned my point of reference is the Lombardy region and in particular the province of Varese.

It is, in a general sense, still that which was defined in the Eighties and Nineties and, as far as residential structures are concerned in the following decade too, with some important modifications due to the reorganization of the Regional Health Services which came into effect with the 1997 Law 31 and from the norms and guidelines of the long term regional planning that specifically concerned both territorial and residential psychiatry.

Monocentrism, represented by Varese's psychiatric hospital where territorial services had been adopted almost immediately after its opening in 1939, as the last of the psychiatric hospitals to be built in Italy, and considerably increased under the direction of Edoardo Balduzzi and later under Carlo Romerio, was, from 1981, taken over by the UOP (Psychiatric Operative Units). These were responsible for several USSLs *(Local Social-Health Units),* authorities that came into existence with the application of the Law 833/1978, instituted by the National Health Service.

Initially, the activation of the Hospital Services for Diagnosis and Treatment (SPDC) in the general hospitals expressly provided for by art. 6 in the Law 180, which still retained ties of dependence to the Psychiatric Hospital Management in its transitory phase where new admissions, however, had been blocked, concerned the hospitals in Varese and Busto Arsizio.

In 1981, roughly about the same period that the Psychiatric Operative Units (UOP) were put into practice, a third service was also activated, the Verbano Psychiatric Operative Unit, with Hospital Services for Diagnosis and Treatment (SPDC) in Cittiglio and subsequently, in 1996 UOPs in Gallarate and Saronno.

Every UOP had a Hospital Service and at least one CPS in each USSL under its jurisdiction. On the basis of regional laws, during the second half of the eighties, in Varese in 1986, the first residential structures came into being: the CRT *(Residential Centres for psychiatric therapies and rehabilitation).*

In the following decade, with the application of the 1992-93 ministerial decrees modifying the 833/1978, the Lombardy region under the 1997 regional law 31/1997 introduced, as previously mentioned, profound changes in the operational procedures of the entire health sector. These separated the programming and control, assigned to new institutions, the ASL *(Local Health Authorities)* with a wider territorial responsibility compared to the USSL, often coinciding with the provinces, from those providing specialist services, in which also included were those provided by the UOP, which came under the responsibility of the general hospitals (AO: *Azienda Ospedaliera -Hospital Authority)*

At the same time, the USSL were abolished, with the creation of the *Departments of Mental Health* (DSM) including one or more UOP and relationships between the ASL-DSM and DSM-UOP were defined.

The DSM is the organism that includes all the structures in any given territory and their job is to take charge, in terms of coordination and planning, of the care, assistance and safeguarding of mental health.

At the end of the nineties, in order to cope with the requirements derived from the definitive closure of the psychiatric hospitals (1999), that had retained a temporary role for patients who could not be discharged, without however the possibility of admitting new patients and those with chronic diseases, the *Residential Communities* came into being. These were structures managed directly by the Health Services or by private accredited facilities that the Region then decided to further differentiate, according to the purpose (mainly rehabilitation or assistance), the intensity (high or low) of the interventions necessary relating to the type of patients admitted, with differentiations concerning the organogram of the personnel, their working hours and also the payments to the hospital in relation to the length of hospitalization.

The Nineties also saw the arrival of *Day Centres*. These, too, were run by the Health Services or by private accredited facilities followed by the latest opened in 2009, the *Light Residency,* another form of residential care with both low protection and cost that provided solutions for individual patients or small groups, with only limited support from health professionals, to achieve greater autonomy. It should provide a bridge between the Communities and the recuperation of

complete autonomy but for some patients it can also be a long-term solution.

Recently, further modifications to the Lombardy legislation for improvements in function and cost/benefit ratio, have led to mergers of the ASL and AO and broadened the scope of the DSM.

From the mergers of the ASL of Varese and Como came the ATS Insubria (Insubrian Agency for the Safeguarding of Health, while the Varese AO has become ASST - Sette Laghi; Seven Lakes Social-Health) and includes the hospitals in Varese, Tradate, Luino, and Cuasso al Monte while the Mental Health Departments in the province have been reduced from three to two, and have acquired the responsibility for Ser.T. (Drug Addiction Service).

The Law 180, with its drastic reduction in beds, reserved for the management of critical situations has also considerably modified the way many pathologies are managed that in the past had the psychiatric hospital as a reference for both short term and long term care. Drug addiction alone, in that period, mainly due to alcoholism, amounted to 25% of total admissions and came under the auspices of the newly formed SerT (Drug Addiction Service). Psycho-organic pathologies, outcomes of ageing, dementias, in their various etiopathogenesis and some confusion and amentia syndromes, which made up 23-24% of total admissions, were dealt with by other Health or Welfare Services (6).

Apart from competency on pathologies, the move to centralize assistance to the Psycho-Social Centres, leaving the hospital to deal with only extremely critical situations, also considerably modified the approach to the various conditions of psychic suffering. In addition to psychopharmacological therapies, individual or group psychological and psychosocial treatments have assumed increasing relevance and it has finally been possible to introduce a form of rehabilitation with the purpose of social reintegration.

The CPS, besides clinical activities, has also taken on a central role in integrated assistance. This was thanks to the multi-professionalism of the operational team, becoming part of a wide network of social assistance within the community, while broadening the scope of their activities, in collaboration with others (Public entities, associations, individuals) who are interested in programmes of prevention and initiatives concerning the modification of cultural aspects and prejudices. These had been the causes of social exclusion and marginalization of which the mental hospital had been an emblematic expression that had affected and even now still affects persons with psychic disturbances.

I have given a broad description of this in various chapters of my previous publications (7).

Over the years psychiatry has however seen a marked change in the clinical outcomes that have remained within its competence and the onset, for a variety of reasons, of new pathologies.

The nosodromia of psychosis besides changes brought about by various pharmacological, psychological and social approaches has been considerably influenced, in cases that once would have been long-term hospitalization and institutionalisation, with the exception of critical situations, by management in outpatients' or day-care centres.

Many are the considerations that can be put forward concerning treatments in residential structures but these will be the subject of future analysis.

Over the years it has also been possible to ascertain the emergence of new clinical forms of psychic distress with a considerable increase, particularly among the young, in personality disorders, the result of changes that have taken place in society in recent years.

Above all changes have occurred in reference values, the concept and types of the family, the approach to sexuality, the relationship between children and parents often disturbed, adulterated or absent, the entrance age and ways of carrying out job activities, the age of reaching psychological and economic autonomy and also, in certain situations, changes determined by the migration of persons from other ethnic cultures. All of this has led to the appearance or accentuation of various forms of dependency not just on substances with easy suggestibility, but conditions of low self esteem and loneliness or vice-versa dangerous aggression, the search for affirmation or compensation often through abnormal methods and a rejection of rules, all conditions that facilitate the emergence of genetic or epigenetic fragility.

These phenomena have been particularly exacerbated in the last two decades but they had already begun to manifest themselves previously. In fact, during the Fifties, the World Health Organisation had, quite rightly, when redefining the concept of illness, that had

historically been interpreted preternatural and later naturalistic, underlined the importance of social cultural factors in its aetiology, specifying, as remembered by Gilberto Corbellini, that the processes can depend on genetic and epigenetic alterations but that these

> operate within ever-changing contexts; therefore the same causes give rise to different clinical forms on the basis of the life experiences of each person affected. This would suggest that the concept of illness must take into consideration both evolutionary and functional factors and the burden of individual experience within a determined social-cultural context. (8)

In the second half of the last century, when compared to a previously long period, psychiatry had radically changed its epistemological references and its *modus operandi* even if it is true to say that this had begun before the 180, the law itself made many of these changes unavoidable.

The crisis in biological psychiatry and the problem of ethics for the care and assistance of persons with psychiatric disturbances was born, as previously mentioned, with the conceptualization of Ludwig Binswange and phenomenological philosophy (Husserl and Heidegger in particular) that permitted overcoming the exclusion that even Freud and Jaspers had maintained with regard to psychotics. The former due to retaining them unsuitable for the transfert, the latter because of his ideas of conceptualizations of incomprehensibility and not partecipation, genetic misunderstanding concerning deliriums, not participation for the supposed inability of psychotics to internalize the experiences of others.

Biological psychiatry that was itself, in many respects, a hypothesis devoid of significant scientific validations, was replaced by psychological psychiatry, or rather many kinds of psychological psychiatry with reference to meta-psychological hypotheses even though not scientific and, for this reason in fact, long rejected by official psychiatry that was anchored to the hypotheses which had as its reference the concept of disease expressed by Giambattista Morgagni.

The references were initially Freud, the psychoanalysis and its metapsychology, born at the end of '800 and the many other metapsychologies later developed inside and outside of this (Alfred Adler, Gustav Jung, Melania Klein, Heinz Hartmann and later Jacques Lacan, to name just a few of the most important authors and founders of schools of thought) (10). It was only after the mid 20th century that they were accepted into official psychiatry, even though it is only correct to remember previous experiences such as those of the American psychiatrist Henry Sullivan (in the Thirties and Forties) with his *The Interpersonal Theory of Psychiatry* and his attempts to extend forms of treatment inspired by psychoanalysis to schizophrenia and those of the French Paul C. Racamier and George Daumézon (in the Fifties) with their *Institutional Psychotherapy*.

In the second half of the twentieth century, however, other types of psychological psychiatry with reference to metapsychology came into being. These were founded on other aspects of mental activity, the principles of which were *Cognitivism* (Aaron Beck) and the *Relational-Systemic theory* (Gregory Bateson) and were often the doctrinal reference for activities emerging in the newly adopted facilities after the 180.

Also to be remembered is *Social Psychiatry* that came into being at the same time and which was not so much an alternative to other procedures but rather an integration and completion of them.

It may be said that its theory is independent of the causes of mental illness that can be social, psychological or biological

> for persons with these disturbances, it is the environment of the community where they live that must become therapeutic so that they can find conditions of equilibrium and the possibility to recuperate and reintegrate into society. (11)

However, just when biological psychiatry, which all in all had not gone beyond the asylum and shock therapy, seemed to be completely unsuccessful, an event contrary to the evolutionary trend in new concepts and therapeutic practices suddenly brought it back to life. This event was the birth of psychopharmacology.

This created problems from an epistemological point of view, not so much for social psychiatry, but for psychological psychiatry and of compatibility and

coherence between psychotherapy and pharmacological therapy.

They were ideological problems and derived, for psychological psychiatry, from the conviction and alleged self-sufficiency of their theoretical approaches. This was the topic of debates and meetings that landed on the pages of the psychiatric section of the Medical-Surgical Encyclopaedias (Jean Guyotat and M. Marie-Cardin). (12)

The diverse positions taken went from an alleged incompatibility, to the acceptance of their synergy, with a yes or no separation of competence between the psychotherapist and the psychiatrist.

Psychopharmacology represented a considerable step forward in the treatment of psychosis. However, it also had the merit, due to the understanding of brain physiology, of furthering considerable development in the knowledge of neurotransmissions and of providing a relevant contribution to the development of neuroscience, which had become, after long-term neglect, one of the most advanced sectors of bio-medical research. The interest in this aspect of scientific research, which is by its nature multidisciplinary, involved, as far as mental activity is concerned, above all neuropsychology and philosophy, with Philosophy of Mind that attained its own autonomy both in research and teaching.

As for neuropsychology, which has become, thanks to new investigation techniques such as fMRI, PET and many others, in all respects, an experimental science, it has been able to achieve innovative results, not only on neurobiological correlations of cognitive processes (Elkonoon Goldberg) (13) but also on affectivity and decisional processes (Joseph Le Doux) (14), (Antonio Damasio) (15), even managing to render the study of consciousness an autonomous experimental science (Stanislas Dehaene) (16), something considered unthinkable until not long ago, for its non-reducible subjectivity.

Psychiatry, although involved in biological aspects under its jurisdiction, did not play a significant role in the development of neuroscience, maintaining a distant and sometimes suspicious position, closed in a *de facto* dualism. And that, as I have previously said,

> for various reasons, that on the one hand, has its own prerequisites in the different ways of proposing itself, quite rightly defended, when compared to other clinical disciplines, in the relationship to the sick, that favours inter-subjectivity rather than objectivity of the empiric sciences [and somatic medicine], and on the other hand because, after the divorce from neurology, which only came about fifty years ago, the prefix neuro- is frequently seen as a threat to one's own identity and autonomy and as a dangerous return to impositions that are too biological and reductionist. (17)

In effect, however, the enormous progress attained in neuroscience in the physiology of the brain, is opening up a new phase in the history of psychiatric doctrine.

After an extended biological period characterized by the equating of mental disturbances to somatic illnesses such as diseases of the brain and a second period during the Sixties of the last century, with the many types of psychological psychiatry born, in contrast to previous psychiatry, refering to the numerous forms of metapsychology previously mentioned, a third period is now emerging characterized by a newly-found non-divisive psychosomatic unity, which evaluates biological, psychological and social aspects, thereby giving them a scientific validation that the doctrine of the previous periods did not have or had only partially.

And this also provides confirmation concerning the mind-brain relationship, of the monistic hypothesis from which differs only slightly the latest dualism of Karl Popper and John Eccles (18) who with the acceptance of evolutionism and neo-emergentism recognizes the causal link between mental activity and neurobiological substrate, placing both in a naturalism with the same laws.

The effects of the Law 180 that most underline what it was and what it provoked in psychiatry, more than in specific indications on its organisation, lie in the fact that they sanctioned the end of an era and determined the beginning of something new and completely different.

The period of psychiatric renewal, which goes from 1963-64 to 1978, had seen two opposite schools of thought. One that was prevalent for about ten years which had as its reference the French experience of

Sector psychiatrists, considered the problem of eliminating the psychiatric hospital as a goal to be reached gradually and had even inspired a bill, the Balconi bill of 1965 (19) that had aroused great expectations but had in fact never materialised. The other, more political and revolutionary became dominant in 1972 onwards, backed by Basaglia and the MAI (Anti-Institutional Movement) that proposed as a single objective the closure of psychiatric hospitals, considered anachronistic, ethically unacceptable and anti-therapeutic, in spite of the changes brought about by the 1968 Law 431 (Mariotti Law) that had permitted voluntary admissions for medical examinations and treatment, abolished judicial registers, introduced by the Rocco code in 1930 and defined some standards for the organograms and organisation of psychiatric hospitals.

As ideological references, in their most radical expressions, it had the denial theories (Thomas Szasz) or in any case interpretations of mental disturbances that placed them more in an anthropological and sociological category than a medical one.

Both these schools of thought, however, were well aware of the ethical problem of the brutality of institutionalization, expressed by deportation, social exclusion, isolation and a life style that left little or no space for personal choices, naturalness and privacy.

Sector Psychiatry, born in France in the Forties with the conceptualisations of Lucien Bonnafé who, considering the internment of metal health patients as "primitive", had proposed a welfare policy that would place an emphasis on the natural and social environment they had come from, which would favour their recovery. It was not, as some had thought, a merely organisational proposal but a bona fide ideology with the aim of eliminating the asylum.

Bonnafè's ideas had been put into practice in a pilot scheme carried out from 1954 in the XIII district by Philippe Paumelle, Serge Lebovici and René Diatkine and in 1960 Sector Psychiatry was made official in France with acts and directives of the Ministry of Health.

Its innovative significance is perfectly expressed in some keywords:

- *Territory* (or rather area or sector) to underline the shift of centrality in the care and assistance of persons suffering from psychiatric disturbances from the hospital to the territory and the competence of the team;
- *Multi-professional team* because the needs of the patients, multiple and complex and not only clinical, cannot be tackled with only a traditional doctor-patient relationship;
- *Taking charge* because these needs must not be just highlighted and analysed but managed directly and professionally;
- *Therapeutic continuity,* with a single hospital and territorial team to indicate the uniqueness of the therapeutic and care relationship, necessary for solving one of the most important problems of psychotic conditions, the difficulty of creating and maintaining meaningful relationships.

During those years there were various experiences of Sector Psychiatry or at least the start of territorial activity and among these the most important was that in Varese, which extended over the entire province. The promoter was Edoardo Balduzzi, during his direction of the psychiatric hospital from 1964 to 1968.

Because of his knowledge and rapport with French psychiatry and the "Sector" ideology he became, in those years, the guiding light.

Despite the friendship between Balduzzi and Basaglia, confrontations on the experiences that they had both encountered materialized in meetings in Varese and Gorizia, when in 1972 the climate changed and references to Sector were suddenly abandoned and experiences and renewal programmes, as they were not aimed at an immediate closure of the hospitals, were considered to be in collusion with the asylum.

History, in recounting these experiences in the decades to come has, generally speaking, has been none too kind.

Only in recent years has there been a reconsideration of that time as being, in fact, an experience that had anticipated that which is or would like to be psychiatry today: a psychiatry that in its relationship with society has built or is endeavouring to build, albeit with regional and area diversities, its new paradigms.

It may therefore be said that with the 180 Sector Psychiatry and Balduzzi both gained a victory. It was

> in a different name, less technical but emotionally more captivating, *community psychiatry.* Some

> wordings at that time found a more precise and accurate conceptualisation, other things have also changed. For example, better clarified was the role of psychiatry within the social framework with the evaluation of other subjects: the families, associations, single persons or groups in civil society, that operationally, in fact, often acquire greater relevance that the Health Services themselves. Better specified also was the concept of culture, in its values and symbolic expressions, positive and negative, for the effects and the relapses on distress and psychic disturbances. The concept of taking charge has been extended, although technically it still predominantly bears professional references, socially it should however be much broader. The roots of all this nevertheless lie in the keywords of those bygone years: *territory, multi-professional team, therapeutic continuity, taking charge,* and in those of phenomenological derivation of *relationships* and *intersubjectivity. (*20)

In perfect continuity with his previous experience during the Sixties and Seventies a further contribution made by Balduzzi to the renewal of psychiatry and in this case also to the implementation of the 180, was the proposal, in 1986, for the setting up of a working group in the Provincial Administration under the acronym of GLP (Psychiatric Working Group, later modified to an extended expression, Provincial Working Group for Mental Health).

The GLP, that two years ago completed thirty years of activity, is both unique and exemplary in Italy because it has signified a different way of practising psychiatry. It is a working group open to Health Service operators, family associations and volunteers and persons who for various reasons are interested in psychiatric renewal in which, without any hierarchical and operative constraints and without subtracting anything from the institutional competences and relations with the individual UOP interact with the territory, compare evaluations, suggestions, proposals and initiatives.

One of the problems that psychiatry had to face in its reorganisation after the 180 was that of finding the right connections in the territory for introducing itself into the network of various social and health agencies, coming out of an isolation that had concerned not only the patients, and the ability to influence those complex prejudices and cultural aspects of society that had determined and determine even today stigma, exclusion and isolation.

In fact, the asylum besides being a physical place is also a mental category whose virtual walls are much more difficult to break down and this group has made a significant contribution to dealing with this problem.

The most important leverage in this was the alliance of the Health Services with family members and their associations, not only for reciprocal comprehension but for doing things together, comparing assessments, aims and programmes with interventions, outside the specific competences of the Health Services and institutional technical meetings, that have, however, proved to be invaluable for the results that they have achieved.

This alliance proved useful to the associations themselves, that thanks to the initiative of a Varese journalist, Lisetta Buzzi Reschini, founded the Co-PASaM (Provincial Coordination of Associations for Mental Health). This too was both unique and exemplary and it gave the family associations and volunteers the possibility of creating a partnership with the Institutions, otherwise impossible for separate associations.

It was, however, an important conquest for the Health Services as well and a highly effective way of influencing society and its culture.

Many were the initiatives put into effect that should be remembered: interventions in the schools and in public demonstrations, raising awareness in Government Bodies and public and private structures, activities for the patients themselves and the promotion and their participation first hand in formulating programmes and activities that concerned them. (21)

Present day psychiatry, all things considered, presents precarious and critical aspects above all evident, albeit with pros and cons, in the new residencies.

This is how Armocida summed up the situation a few years ago:

> If unexpectedly, in the singular political and cultural atmosphere of 1978, the law came into force that suppressed psychiatric hospitals by substitut-

> ing them with treatment of the patient in his own familiar and social environment, after thirty-five years the "credibility" in long-term care has returned. […] If we take a look at where psychiatrists and patients are today we can realise that the manifestations of the revolution, together with the fantasies of those who were enlightened with the idea of being able to renounce places of "segregation", no longer have the same voice as in the past. Perhaps psychiatrists have changed their ways and are no longer in the blaring positions that had led them forcibly to the Law 180. While asylums have now been dissolved, many comments are possible, but it must be recognised that the same outsourced assistance that worried psychiatrists in the past, knows moments of undeniable fortuity allowing a certain amount of flexibility in terms of healthcare solutions. (22)

The way in which the problem of chronic care has been tackled, for which these structures are destined, is in effect full of ambiguity in the way it has been evaluated and for the uncertainties and errors in how the solutions have been determined. The concept of chronicity, as far as psychosis is concerned, is the example of ambiguity because besides the clinical criteria all too often ideological prejudices are also expressed. Residency in psychiatric mental institutions was intended for the persistence of symptoms above all if these were expressed with behavioural disorders and the incorrect assumption that an ordered lifestyle away from family or pathogenic environments contributed to their improvement. The new residencies, on the other hand, are derived from a declared emphasis on the disability aspect and rehabilitation as its declared motive, failing to mention instead a negative prognostic judgement as far as recovery or precarious and difficult existential situations are concerned.

The problem of severely ill patients with persistent symptomatology applies not only to Italy. Even advanced legislation such as that in France in 2005 speaks about psychic handicap as equivalent to persistent chronicity and of Treatment Units as organisational solutions for difficult patients.

The region of Lombardy, as previously mentioned, had foreseen, as residential structures, first the CRT, then Therapeutic Communities highly differentiated by type with a further form of low protective residency: light residency. This complex legislation in Lombardy would seem to be an optimal method for giving adequate and diverse solutions to the various needs of the users while also paying attention to the cost/benefit ratio. In reality, however, this has not been so. The criticisms that can be made are multiple and regard both the legal aspects and the management. To indicate just a few: Therapies conditioned by different types of communities on the basis of the intensity of the intervention and the conditions of the patient foresee a complete resetting and restarting instead of an indispensable continuity in the therapy in patients that already have difficulty establishing meaningful relationships; the time constraints penalizing the length of rehabilitation make it easier to fall into welfare categories; the lack of territorial restriction in the choice of the community, even though allowing in its activities interventions aimed at maintenance and a recovery of "ability", makes it more difficult or even impossible to programme social inclusion, partial and gradual experiences of autonomy are in conflict with the regulations concerning the running of the Communities. Ample arguments can be made for each and every case.

This is the conclusion I had reached, speaking about this problem in one of my earlier publications:

> In therapeutic communities the inadequate investigation into the problems connected to persistent chronicity of severe psychic patients, all to often collocate these persons in a dimension that is almost exclusively assistive, proposing many of the objectives that are characteristic of the asylum: marginalisation, exclusion, in many cases deportation, difficulties, obstacles and renunciation of projects leading to even partial recovery. The improved quality of life and the attention that most of these institutions reserve for restoring abilities, or at least for maintaining them, does not modify judgement, particularly if the assessment is prospective. The low turnover, the result of experiences that come about simply from the changeover from one community to another or for not renewing the programme already initiated, without having obtained results

> from programmes and treatments carried out, also paves the way for other effects, already seen in the asylum or as a consequence of their closure without taking adequate account of the real needs of the patients: the progressive number of patients deposited in this area or on the contrary situations of abandonment. However, it is not fair to paint everyone with the same brush and it is necessary to evaluate situations that due to their initiatives are of a less negative prospective, […] the consideration that may be made is that this is one aspect of the psychic health organisation that is already present to some extent and could later have even further regressive developments, surreptitiously proposing exactly what the 180 wanted to finally eliminate. (23)

This is a short excerpt from an article by Francesco Cro, psychiatrist and coordinator of the DSM in Viterbo, in the publication *Mente e Cervello* (Mind and Brain) (magazine associated to Le Scienze) in June 2014, that deals with the same subject from a more general point of view.

> Closure of the asylums, but perhaps it is not enough. The Italian psychiatric legislation concerning the closure of the asylums represented an original experiment, viewed from abroad favourably or critically, but in any case with interest […] however numerous residential structures still remain throughout the country, in which patients are accommodated in the long term and therefore the problem of chronicity and institutionalization remains unsolved […] Simply abolishing the asylums by law is not sufficient, therefore, to tear the patients away from containment structures and reintroduce them into society. Research coordinated by Stefan Priebe, lecturer in social psychiatry at the London School of Medicine, has drawn attention to the risk of an increase in admittance to residential structures that is underway in six European countries that had, on the contrary, set up reform programmes to "deinstitutionalize" – Great Britain, Germany, Italy, Holland, Spain and Sweden. Italy and Holland. Holland, especially, had shown an increase in places in […] protected structures superior to the decrease in places in asylums, while the prison population, that often has to take in persons with psychic problems, has increased in all of these six countries. (24)

And this also has had objective confirmation in the province of Varese. (25) Problems however also exist in territorial psychiatry, even where it has been possible to evolve into *community psychiatry*, which represents the real aspect of innovation compared to the past.

Some are problems that exist not only in psychiatry but all branches of medicine, particularly in recent years. The excessive bureaucracy that concerns all facets of activity and therapeutic interventions, developed for control purposes, after dividing the organisation into Authorities that programme, authorize and quantify economically the health services and other Authorities that put them into practice in their institutions, has ended up privileging merely documentary formalities, taking up a considerable part of the operators' time (particularly those with responsibility), subtracting it from clinical activities. The reduction in health costs in certain sectors has often penalized staffing and reduced activity resources that in psychiatry have concerned above all rehabilitation.

And the effects of these two problems are summed together.

The other aspect, above all for psychiatry, concerns the number of beds in the SPDC. Those foreseen are roughly 1/10.000 inhabitants, in the province of Varese 75 for a population of approximately 850.000 inhabitants (data from 2015), slightly fewer than what there should be.

This sometimes makes admissions precarious with temporary recovery outside the area and, due to necessity, discharges are often hurried which only facilitates subsequent re-admissions.

The conclusions to be reached in judgement of the 180 and what has happened after its activation should therefore necessarily be noted. On the one hand its ideological and symbolic significance means that its relevance remains unchanged: it is a divide that marks a "before and after" and the 'after' has opened up completely new horizons, shifting the centrality of psychiatric intervention to the needs of the persons and re-

storing their dignity rather than, improperly, to that of society. On the other hand, due to later developments, that have seen delays, criticisms and diversity from area to area but have also had to come out of utopia and come to terms with the clinical reality, often not easy, with the evolving of scientific knowledge and the changes in society and its culture, we can say that it is a law where everyone has come out on top.

Basaglia and the Anti Institutional Movement (MAI) have gained, with the destruction of the asylum that as it was before will never surface again; Balduzzi, too, that with his Sector anticipated *community psychiatry* which is the concrete alternative to previous institutional solutions; psychiatry, also, as a discipline of medical-biological naturalism that neuroscience and psycho-pharmacology have validated with their scientific evidence and finally the asylum itself that at times is re-proposed disguised in other shapes and sizes.

The last words on this subject go to Armocida, resuming the previously mentioned text:

> In a highly complex horizon, among so many differences, many of the past uncertainties remain and the opportunity cannot be missed for renewing the importance of some concepts of timeless value.
> Psychiatrists follow their path like explorers who continually circumnavigate their destination, they get nearer, sense that they are close but caught between transformations and contradictions, understand all too well that the spaciousness of thought is often in contrast with the desperate straits of everyday clinical life […] Following a natural evolution, many significant ideas of the past have lost importance in the interests, culture and professional life of psychiatrists, in repeatedly veering backwards and forwards that often, even in recent history, has led to correcting and modifying the objectives. We can but reflect and take awareness of this. (26)

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Correspondence:
Mario Augusto Maieron
ASL Varese
(now Agenzia di Tutela della Salute – ATS - dell'Insubria)
E-mail: mario.maieron@alice.it