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Deinstitutionalization in Italian psychiatry – the course and consequences. Part II. The consequences of deinstitutionalization

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Summary

The Italian mental health care is based on Law 180 (it. Legge 180), also called Legge Basaglia, from the name of the author of the reform, Franco Basaglia. It was adopted on May 13th 1978. The new legislation resulted from the actions of a strong anti-psychiatric movement and it brought about a major change in the organization of psychiatric care. The reform and its consequences were widely studied by the researchers, especially in the United Kingdom and the United States of America. The authors point out many successes of the reform, especially in its beginning. They seek the sources of its failure in a faulty and incomplete implementation. Legge Basaglia completely changed the structure of mental health care in Italy, finally bringing psychiatry back to medicine and the general hospitals, as well as promoting community-based psychiatry. Deinstitutionalization in Italy was not related to an increase in compulsory psychiatric hospitalizations, suicide attempts by the mentally ill, nor did it raise the number of crimes committed by them. It also did not cause common trans-institutionalization, with the transfer of patients to the private sector, as predicted by its opponents.

Key words: deinstitutionalisation, psychiatric reform in Italy, mental health care in Italy

Introduction

The introduction of Legge Basaglia was the culmination of the work of Basaglia and the Italian anti-psychiatrists. Their ideas and anti-institutional experiments were the sources of the Italian psychiatric reform [1]. Law 180 (known also as Legge Levy, from the name of the psychiatrist Mark Levy, one of Basaglia's co-workers) was the realization of Basaglia's core postulates on bringing psychiatry closer to general medicine (and further away from the legislature) and community-based care of the mentally ill. However, the main aim of the reformers was to break down the system of psychiatric hospitals. The new law introduced: ban on building new psychiatric

hospitals, prevention of the transformation of current psychiatric hospitals into profiled departments of general hospitals, reduction in number of beds in psychiatric departments in general hospitals, and more rigorous criteria of compulsory hospitalization (which was finally supposed to be terminated) [2]. Based on Legge Basaglia patients were gradually released from psychiatric hospitals. The end of 1981 was the date after which patients would no longer be admitted to psychiatric hospitals. Since 1982 the only patients would be those previously hospitalized, those requiring inpatient treatment and on clear demand of the patient. Compulsory hospitalization would only be possible on the basis of an opinion of two psychiatrists, accepted by the authorities and would last only up to 7 days. Psychiatric departments in general hospitals were supposed to cover a region of 200 thousand inhabitants and provide up to 15 beds, which would lead to mass lay-offs of staff.

The management of the new psychiatric care system was to be led by a new network of regional departments of mental health (Dipartamento di Salute Mentale – DSM). The law imposed creation of mental health centers (Centri di Salute Mentale – CSM), based on the British system, providing care in particular regions. A range of new additional psychiatric care institutions was also supposed to be created. Of course, community-based mental health care existed in other countries with a shorter (in the USA) or longer (UK) tradition. The difference was that in Italy it would be an alternative to inpatient units, not a complementary addition. According to the authors of the reform, the experiences of deinstitutionalization in the years 1961–1978 proved that a complete replacement of psychiatric hospitals with alternative form of care is possible.

The consequences of Basaglia's reform

The reform has led to creation of a system of mental health departments (based on geographic division) with significant autonomy in administrative, financial and medical affairs [3]. The new system encouraged the development of three types of alternative care centers: 1) psychiatric departments in general hospitals (Servizi psichiatrici di diagnozi e cura – SPDC) – small units with an average of 13 beds (15 maximum), up to 10 rooms, a low staff count, acquiring mostly patients with psychotic disturbances; 2) mental health centers (CSM) running 12 hours/day 5–6 days per week with multidisciplinary team organizing care by admissions, consultations, crisis interventions and supporting the mentally ill in contacts with social care; 3) social care centers concentrating on occupational therapy and helping patients to find new jobs (currently about ¼ of them offer psychotherapy).

A delay in the implementation of the reform was due to a lack of executive directives in the areas of financial affairs, standards of outpatient care, status of new units and standards of training of the hospital staff, who were supposed to re-qualify in order to work in the new system. All of these duties were passed to the local authorities. Achieving satisfactory results in a short period of time was impossible because of regional disproportions. The local authorities' attitude towards the reform was diversified:

from ignoring the new law in the south, to its gradual implementation in the north and swift and efficient imposition in some regions. In effect it has led to the formation of three different models of psychiatric care in Italy [4]. To date, differences in standards of care and treatment are visible and some regard the "Italian model" of psychiatric care as nonexistent [5]. Variability of the rate and effectiveness of implementation of Legge Basaglia was especially visible in terms of difficulties in building new units and programs of community-based care. The critics of the reform saw this as a proof of flaws in the reform, while the supporters viewed it as a lack of proper management [6, 7]. The regions where the reform was quickly implemented were shown as examples of the system functioning well [8, 9]. The Ministry of Health, aiming to change the situation, implemented national standards only 20 years later, in the years 1994-1996 and 1998-2000 [10]. At that time the Ministry of Health imposed fines in the regions which delayed the implementation of the reform or which did not fully implement the reforms. A directive to finally close down the hospitals was introduced and more support was given to the mental health centers (CMS). The end of the implementation of the reform was announced in 1998 and by that time all of the psychiatric hospitals had been closed down.

The gradual shutting down of the psychiatric hospitals is the main consequence of Legge 180 from the point of view of psychiatry. During the first decade since the adoption of Legge Basaglia, the number of psychiatric patients was reduced by 53% [11]. Later on the rate of the fall slowed down, to reach 62.5% after the next two decades [12]. During 20 years (1979-1998) the number of psychiatric patients was reduced from 78,000 to 7,700. It is worth pointing out that the reduction of patients in the upcoming years resulted directly from the limitation of hospital beds (up to 15 per department) and was related to political and economic pressures to close down the hospitals. The most drastic were the years 1996–1998, when the number of patients fell by 45%, from 17,000 to 7,700 [10]. During the first decade since the implementation of the reforms, the number of admissions to hospitals was also significantly reduced, from 4.78 per 1000 inhabitants in 1975 to 2.78 in 1987 and 2.22 in 1994 (these numbers do not apply to the private sector, where the number of admissions remained at a stable level of 1.5 per 1000 inhabitants) [13]. However, when taking into account the absolute values, the situation looks somewhat different: the number of admissions increased from 87,000 in 1979 to 136,000 in 1997, which is thought to be related to a short period of hospitalization, too short for many of the patients (14.5 days in 1997 – half of the time compared to the UK) [12]. The number of compulsory hospitalizations decreased by almost 60% in the first year of the reform. In the years 1979–1997 the percentage of compulsory admissions compared to all admissions decreased from 17% to 10.6% [14]. The number was lower than the European mean. The Italian trend was in opposition to the rest of Europe, where the number of compulsory admissions was rising [12].

The creation of social cooperatives in the 70's, as part of governmental plans of deinstitutionalization of psychiatric care, was a phenomenon in Europe and a specifi-

cally Italian idea, which brought important social consequences. The aim of these activities was to reduce the burden of social care, provide the economically impaired with alternative ways of earning and to ease the social tensions related to unemployment. People threatened by social marginalization were hired in the cooperatives, functioning in special legal and economical conditions. These cooperatives were types of companies, with the patients as shareholders together with the healthy employees. Many actual and former patients profited from this solution. This was a realization of some of Basaglia's ideas, from a decade before. Basaglia supported the professional activation of the patients and dispraised their unpaid work, which he saw as economical exploitation. The system applied also to the unemployed and impoverished former employees of the psychiatric hospitals. This specifically Italian and grassroots model of the cooperative was the main social consequence of Basaglia's reform. In 1991 it was legally sanctioned in a way that the anti-psychiatrists fought for – the psychiatric patients were considered, together with the drug-addicted and former prisoners, as a group with a right to work and to hold executive positions in the cooperatives.

The consequences of the reform and the Italian system based on Triest

The opponents consider Triest, the place of Basaglia's larger experiment, advertised as a model example of Italian reform, as non-representative. The model of psychiatric care was created by Basaglia during four years (1971-1975) and profited from the directives of the law from 1978. A large hospital with 1200 patients, situated in a typical complex of buildings from the Austrian times, located on the city's peripheries was transformed into an open unit. In 1980, in accordance to Law 180, it was shut down. Since 1981 a Department of Mental Health is functioning in Triest, financially supporting social cooperation, mainly emancipation programs for people with mental disorders. The total number or employees was 248 (28 psychiatrists, 9 psychologists, 141 nurses and other staff members), which is half of the number from 1971. 1.3% of the inhabitants use the psychiatric care system (in 2010 the population was 205 530). In the city there are four mental health centers (CSM) – territorial units (covering around 60 000 inhabitants) with respective administrative areas of the general medical care system. Each of them has a 24/7 mental health center with 6-8 beds. There's also a university clinical center (4 beds, an area of 11 000 inhabitants), two daily care centers and one center for women. They offer treatment plans for different psychiatric disorders. In the general hospital there is a psychiatric department (6 beds) taking care of patients needing hospitalization, coordinating diagnostics and interventions. Some of the buildings of the former psychiatric hospital were given to the university clinic (10 beds), training institutions, university's agendas, other types of centers (addiction treatment, center for the youth, creative artwork and recreation). The former psychiatric hospital and the surrounding area were integrated with the city's divisions, which was possible after changes in the traffic routing. No referral or special procedures are obligatory to receive help within the system. In the last 30

years the number of compulsory hospitalizations was reduced 6-fold and the number of suicides decreased by ¼, which can be considered a success (the data as in [15]).

The current state of the Italian psychiatric care

At the moment around 1.1% of the Italian population is using some forms of psychiatric treatment, from which 28% are first-time patients (data from 2001) [3]. According to the Ministry of Health data from 2006, there were 266 psychiatric departments with 3,500 beds (an average of 13 per department), 23 clinical departments with 400 beds, 16 mental health centers with 24-hour care and 98 beds, 54 private units (all were created before the reform) with almost 5,000 beds and 1,370 other outpatient units with 17,000 places. There were 5,500 psychiatrist employed, almost 2,000 psychologists and almost 15,000 mental health nurses. In Italy all of the psychiatric hospitals were shut down. In a few places there are beds for 2000 chronically ill people [3]. Providing care for these patients remains a problem for the system. In some regions like Lombardy, a resolution automatically transferring patients aged over 65 to welfare houses was implemented, mindless the clinical justification. The total number of beds in the psychiatric departments is significantly lower than the European mean. Almost 30 years after the reform Italy's index of beds in psychiatric departments – 2.9 per 10 000 inhabitants in the public hospitals and 1.7 in private hospitals is one of the lowest in Europe.

The consequences of deinstitutionalization

The supporters and opponents of the reform present different, sometimes extreme views of its outcome. The authors and the radical supporters underline that the reasons for any failures were the political and ideological reluctance and boycott by the establishment. Radical opponents critique the idea and practice of deinstitutionalization as such. Regardless of these subjective opinions, there are some reasons that make the objective assessment of the Italian reform difficult. The publications on the cause and consequences of the deinstitutionalization, mainly British or Italian, are fragmentary. They usually describe individual cases of particular regions (more or less representative) or present an abbreviated history of the legislative reform. Most of the literature covers the first decade after the implementation of Legge Basaglia (around 1989 a peak of interest in the subject was seen [16]). That period is too short to indicate any visible trends. When interpreting the statistical data (published by the WHO or the Italian governmental research reports) it is hard to separate the problems related specifically to deinstitutionalization from the general problems of the psychiatric care. One of the reasons for these difficulties which prevent conducting honest research into deinstitutionalization, is the authority's policy. In the first decade of the 21st century economic pressures forced the authorities to shut down most of the psychiatric departments. In practice it meant only a nominal change, as these units still operated, only

under a different name, using a new nomenclature (e.g. treating patients as guests). Research on the first decades of the reform indicated some significant trends, like the reduction of patients and the reduction of compulsory hospitalizations, which were considered as markers of the effectiveness of the reform. What is lacking is the data on the circumstances of the thousands of patients who quit the hospitals and other thousands that were not admitted to the hospitals. It seems obvious that the reduction of admissions resulted purely from administrative changes; a limited number of beds and legal restrictions on imposing compulsory hospitalization. At the same time, during the first years after the implementation of Legge 180 the creation of alternative forms of treatment was too slow, only achieving a satisfactory level in 1984, which can be considered a success in this manner [14]. Research was also conducted on the incidence of suicides in the general population, in the group of mentally ill and the hospitalized and also on the mortality of the chronically hospitalized patients. These indexes were considered as parameters of the quality of psychiatric care. The research was first conducted in the 80's and 90's of the 20th century and is still being continued nowadays. It did not show a relationship between the model of treatment and psychiatric care and the mentioned parameters. Although some of the indexes showed a growing trend, the causes were linked to economic factors [11, 17–19].

Since the implementation of deinstitutionalization, the number of crimes committed by the mentally ill did not increase [3]. There was an increase in the admission of patients with acute psychosis, which is being linked to a change in the diagnostic criteria [20].

Research on the consequences of introducing a new model of psychiatric care for the families of psychiatric patients is sparse, although it is known that the reform made their lives more difficult. Only some of the families benefit from support of dedicated services [21]. Moving the burden of the care from the institutions to the families has been one of the main problems of the reform. In the 80's of the 20th century it resulted in the formation of a movement of families of the patients objecting to the reform and aiming to reopen the hospitals.

The critics of the new system underline that the changes do not cover a series of disorders and problems like addiction treatment, treating other than psychotic disturbances and treating the prisoners. The new system limited the social range of psychiatric interventions. It resulted in unfavorable changes in the educational and professional profile of the psychiatrists [22]. The environment of academic psychiatry functions on a different basis (practice in clinical hospitals), with no professional contact with the real problems of non-institutional psychiatry [23]. The staff has lower qualifications and lower salaries, with less impact on the effectiveness of treatment. A few widespread analyses on the functioning of public units, conducted 20 years after the implementation of the reform, conclude that the treatment was based in large part on pharmacotherapy, the patients were not provided with specialist care in the areas of psychogeriatrics or child and adolescent psychiatry. There were also serious omissions in the documentation and the evaluation of treatment. Private centers offering

psychiatric care are beyond any public control. The access to psychotherapy is limited, including cognitive therapy and psychoeducation. The research shows that they are only available to a small percentage of patients and their families [10]. In turn, in public hospitals the meaning of consultant psychiatry (Psichiatria di Conzultatione) only gained significance in the 90's. This is also when the network of centers for psychosomatic medicine, psychogeriatrics, psychooncology and similar disciplines were expanded and integrated with the existing system [24]. According to the critics of the reform, the legislators did not predict the difficulties faced by general hospitals related to the treatment of the mentally ill and underestimated the challenges for the services providing care in the community [22].

While evaluating the process of deinstitutionalization in Italy, one must point out that the ideological aim of Basaglia's supporters has been achieved. It was to counteract social exclusion of the mentally ill by promoting a change in the social conscience in terms of the treatment of the ill and their functioning in the society. However, the process was possible in large manner due to the activity of the supporters of deinstitutionalization in the 60's and 70's. The legal reform was an effect of the process, preparing the ground for the realization of some of the important anti-psychiatric postulates. Moreover, the process must be evaluated in a comparative context, especially to the USA. The consequences of deinstitutionalization implemented in 1963 were so destructive for the patients and the society that a well-known historian did not hesitate to call it the "Titanic of psychiatry" [25]. On the other hand the researchers remark that the changes in Italian psychiatry are in accordance with the general global trend to reduce the role of the psychiatric hospital and to replace it with community-based psychiatry [3].

From the current perspective it seems that the opponents of the reform are right in so much as the reform brought change mainly in the field of administration. Psychiatric departments and Mental Health Centers replaced psychiatric hospitals. The new units of care differ from Basaglia's assumptions, with pharmacotherapy as the main way of treatment. However, judging Basaglia's activity from the point of view of current psychiatry would be ahistorical. His work is very significant in terms of allowing for a revolutionary sociological change, opening of the society to the mentally ill and amelioration of their living conditions. The importance of this change was underlined by Basaglia himself, who said that the utopia was achieved (L'utopia della realta, 1974). Opening the doors in psychiatric hospitals, and later their liquidation, not only prevented the social isolation of the mentally ill, but also became a stimulus to implement innovative methods of treatment and activate different non-medical sectors in the therapy, rehabilitation and emancipation of the patients.

In the last years every Italian political party included a novelization of Legge Basaglia in their program. In fact some work on this law was conducted in the government and parliament during the centro-leftist coalition rule. The changes concerned the unification of psychiatric care in all of the regions, reinforcement of psychiatric prevention and psychosomatic care. The proposition of dividing the psychiatric

disorders into three types was also discussed: "domestic" treatment (in CSMs, with ambulatory diagnostics and treatment), "acute" (observation and treatment up to 72 hours of potentially dangerous patients and those in crisis) and "hospital" (treatment up to 90 days).

Conclusions

To summarize the effects of the Italian psychiatric reform, the following conclusions can be made:

- implementing Legge Basaglia completely changed the structure of psychiatric care in Italy, bringing psychiatry back to medicine and the general hospitals and promoting the model of community-based psychiatry [3, 5, 26–28];
- the lack of sufficient financial support for community-based psychiatry was one of the causes of the problems that emerged during the implementation of the reform [22];
- closing of psychiatric hospitals should be accompanied by a substantive alternative treatment, supported by detailed procedures, education, monitoring and evaluation [3, 22, 29];
- legal acts cannot be limited to general regulations, as in case of Legge Basaglia, but should be complemented with detailed executive acts containing standards for crisis intervention and long-term care of disorders such as affective disorders, anxiety disorders and addictions [30];
- deinstitutionalization in Italy did not lead to an increase in compulsory psychiatric hospitalizations, it did not cause an increase in the number of suicides among the mentally ill and did not result in an increase in the number of crimes committed by them [3, 7, 12, 17];
- deinstitutionalization did not cause common trans-institutionalization (transfer of patients from treatment centers do care facilities), with the flow of patients to the private sector. Contrary to the predictions of its opponents the private sector did not grow [3].

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