Psychological Medicine, 1987, **17**, 283–289
Printed in Great Britain

EDITORIAL

The Italian experience and its implications[1]

In May 1978, the Italian Parliament passed Law 180, the main aims of which were gradually to dismantle the mental hospitals and to institute a comprehensive and integrated system of community psychiatric care. Thus, Italy provides an important opportunity for assessing the effect of extensive change in the pattern of provision of psychiatric care. Systematic evaluative studies of the Italian psychiatric reform are becoming more frequent, although there exist in the English language literature many accounts of relatively short visits to Italian psychiatric services. These latter exemplify a wide range of views, from overt enthusiasm on the one hand (e.g. Lacey, 1984), to hostility on the other (e.g. Jones & Poletti, 1985). This editorial attempts a brief review of the reform and its effects, with particular emphasis on quantitative aspects, and we consider issues which may be relevant with regard to changes in the organization of psychiatric care in countries other than Italy.

BACKGROUND

Changes as sweeping as those implied by Law 180 must be considered in context. Italian mental health legislation before 1978 has been described in detail by Maj (1985) but, briefly, the practice of psychiatry was until 1968 governed by statutes and regulations dating from 1904 and 1909 respectively: under their provisions, voluntary admission to mental hospitals was impossible and commitment to a mental hospital was recorded on the court register in a similar way to a criminal conviction. As Maj (1985) observed, 'two opposite purposes existed in the legislation: a custodial-repressive one and a humanitarian-sanitary one... the former objective seems ultimately to have prevailed'. Indeed, as De Plato & Minguzzi (1981) noted, the 1909 regulations governing the management of mental hospitals resulted in 'a rigid institutional structure closely modelled on that of the prison'.

The 'Mariotti reform' (Law 431) of 1968 sanctioned voluntary admission, provided for changes in the organization of mental hospitals and permitted the introduction of out-patient clinics. Maj (1985) observes that, while these reforms clearly represented progress, this was 'more from a theoretical viewpoint than from that of concrete results'. He noted that the attempt to fit voluntary admission into a structure designed primarily for custodial care was a failure and that, despite the out-patient clinics and other services, no significant connection was established between 'hospital psychiatric care and extramural assistance'.

Serban (1977) considered community psychiatry to be first and foremost a social movement, and this is nowhere better exemplified than in Italy. A detailed description of the events leading to the 1978 reform is given by De Plato & Minguzzi (1981), but a brief account is relevant here. The 1960s were years of rapid political, social and cultural change in Italy. This provided a fertile background for the development of a movement for psychiatric reform, the focus of which was the work of Franco Basaglia. He applied an 'open door' policy and a therapeutic community approach (modelled on that of Maxwell Jones) to mental hospitals in Gorizia (Basaglia, 1968) and later in Trieste (both in the northeastern corner of Italy). At more or less the same time, similar developments took place in Arezzo, Perugia and Ferrara.

Participation in these developments was not, however, confined to those professionally involved, and concern with psychiatric reform became an issue of general interest. In 1973, a national

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organization – 'Psichiatria Democratica' – was formed, with Basaglia as its leader. This organization, which became aligned with the left-wing political parties, became an important professional and political pressure group.[1] In 1977, a petition by the Radical party to reform the then-current mental health legislation gained nearly three-quarters of a million signatures. To prevent a national referendum, the results of which might, under Italian law, have forced the Government to resign, Law 180 was introduced in May 1978. The opening of new community services, set up according to the new law, was accompanied in some areas by public demonstrations of rejoicing and support; it is difficult to imagine such involvement and concern elsewhere.

LAW 180 AND THE ITALIAN MODEL OF COMMUNITY PSYCHIATRY

The major provisions of Law 180 were as follows.

(1) There were to be no first admissions to mental hospitals after May 1978 and no admissions at all after December 1981.

(2) Psychiatric units of up to 15 beds were to be established in general hospitals, to which all patients requiring hospitalization – voluntary or compulsory – were to be admitted.

(3) Community psychiatric services were to be set up, each to provide for a specified geographical area and to work closely with the in-patient unit so as to ensure continuity of care.

(4) In cases of urgent therapeutic need and refusal of treatment, compulsory admission may be authorized, on the basis of two medical recommendations, by the mayor or his designate. Such detention is subject to review at 2 and 7 days and there are extensive rights of appeal.

(5) The new facilities in general hospitals and in the community were to be staffed by existing mental health personnel.

As Ramon (1985) has noted, 'this law differs considerably from other European mental health legislation in its goal of completely restructuring the existing organizational framework and, equally important, of guaranteeing the employment of existing personnel'.

Three distinctive features of the Italian model of community psychiatry are worthy of note. First, the phasing out of mental hospitals was intended to be a gradual process – by means of a block on first admissions and subsequently on all admissions – rather than an abrupt deinstitutionalization of chronic patients. This latter pattern was characteristic of the American community mental health experience (Mosher, 1983; Brown, 1985), from which the Italian model therefore differs considerably. Secondly, the new services were designed to be alternative, rather than complementary or additional to mental hospitals. Furthermore, it is hospital psychiatry (which, with the passage of time, is increasingly located in general hospitals rather than in mental hospitals) which is considered complementary to community care, and not vice versa as in most European programmes for community psychiatry (the so-called 'community priority' – Tansella 1986).

Thirdly, integration is intended between the various facilities within the geographically based system of care, the same team providing domiciliary, out-patient and in-patient care, an approach which facilitates continuity of care and long-term support. There is special emphasis on multi-disciplinary teamwork, domiciliary visits and crisis intervention, and on easy access to the community mental health centres.

Changes consequent on the new psychiatric legislation – which, as de Girolamo (1985) points out, was enabling rather than prescriptive – must be considered from two points of view. First, to what extent has the law been implemented – i.e. a matter of provision of structures and thus the responsibility primarily of administrators and politicians – and, secondly, where appropriate structures have been provided, how well do they work – i.e. an issue of function, the responsibility primarily of the 'front line' health care professionals.

[1] It should be noted that, in Italy, the organization of psychiatric services is more politicized than in many other countries. Supporters of Psichiatria Democratica tend to be identified with one particular pole of the political spectrum to a much greater extent than are the proponents of community psychiatry elsewhere. This association between the reform and political ideology may account for the marked polarization, alluded to above, of publications describing the organization of psychiatric services in Italy.

DATA RELEVANT TO STRUCTURAL ISSUES

The first question of structure to be considered must clearly be the extent to which mental hospitals have actually been closed. Morosini *et al.* (1985) and Tansella *et al.* (1987) have analysed national data provided by the Central Institute of Statistics (ISTAT) in Rome (collected using an information system similar to the Mental Health Inpatient Enquiry in England and Wales). These analyses make it clear that the number of beds and residents in mental hospitals in Italy has declined annually since 1963. In that year there were 1·73 public mental hospital beds per thousand population, as compared with 0·76 per thousand population in 1983. There is also evidence that the decline is occurring at an increasing rate: Tansella *et al.* (1987) noted that, between 1963 and 1968, the average decrement was 1390 beds per year, as compared with an average decrease of 3305 beds per year during the pre-reform quinquennium (1973–8). The figure for the post-reform quinquennium (1979–83) was 4140 beds per year, although its validity is obscured by the practice in some areas of redesignating mental hospital patients as 'guests', thereby ensuring that their beds are not included in the ISTAT returns. It is clear, therefore, that at least as far as bed numbers are concerned the 1978 reform legalized a pre-existing trend of deinstitutionalization, a trend by no means confined to Italy (for example, as Gronfein (1985) notes, 'operational deinstitutionalization' preceded 'policy deinstitutionalization' in the United States). It should be noted, however, that bed closure was gradual rather than abrupt, and that there was no wholesale 'emptying out' of mental hospitals.

Tansella *et al.* (1987) further demonstrated that admissions to mental hospitals continued to increase after bed numbers had started to decline: the peak was in 1975, when 1·82 admissions per thousand population were recorded. They noted that during the period 1968–78 (i.e. between the Mariotti reform and Law 180) admissions increased while bed numbers decreased: thus, in the last ten years before the reform, the mental hospitals were beginning to function as hospitals rather than simply as asylums. Admissions to mental hospitals have, of course, declined precipitously since the 1978 legislation, and have been illegal since 1982.

Critics frequently assert that the reform has resulted in a substantial increase in the provision and use of private psychiatric facilities (e.g. Jones & Poletti, 1985; Papeschi, 1985). Private psychiatric hospitals submit annual returns to ISTAT in the same way as public mental hospitals, and Tansella *et al.* (1987) examined these data. They found that beds in such private hospitals were maximal in 1972 (0·46 per thousand population) and that admissions to such beds were greatest in 1977 (0·87 per thousand population). In the three post-reform years for which data are available, private beds have decreased by 7% and admissions to them have remained constant. These data do not therefore support the frequently stated view, although no data exist about psychiatric admissions to non-psychiatric private facilities, such as geriatric hospitals and nursing homes.

It appears that the dismantling of old structures is proceeding according to the law – what of the provision of the new structures, the general hospital psychiatric units, the catchment-area based community services, day hospitals and hostels?

In June 1984, the Centro Studi Investimenti Sociali (CENSIS), an independent social research agency of high international repute, conducted a detailed national and regional study of the Italian psychiatric services. They found that there were 3055 general hospital psychiatric beds (0·05 per thousand population) in Italy, while a further 2071 beds (0·03 per thousand population) were said to be planned. The CENSIS survey also found that 507 catchment-area based community psychiatric services (an average of one service per 112000 population) were in operation and that 32 day hospitals and 86 staffed hostels were in existence (one facility per 1 779000 and 662000 population respectively).

It is clear, therefore, that the provision of alternative structures has been quite inadequate, a conclusion supported by Tansella *et al.*'s (1987) finding that public expenditure committed to mental hospitals is still greatly in excess of that committed to community services. Furthermore, there is evidence of marked regional inequality in service provision. Although Law 180 applies on a national basis, responsibility for its implementation is at regional and local (Unità Sanitaria Locale) levels. Regional differences in Italy – especially the divide between the north/central and the southern

regions – is marked and pervasive. Resistance to and obstruction of change (usually politically motivated) are possible and do occur. Kemali *et al.* (1985) noted that in the south administrators were 'often caught completely unprepared' by the new law, the effect of which is exemplified by his description of the state of affairs in Naples in 1978. Three general hospital in-patient psychiatric units (15 beds each) were set up in 1978. Two of these had catchment areas responsible for patients from the entire city of Naples (about 1·2 million people), while the third was responsible for patients from the remainder of the province (about 1·6 million people). Furthermore, no other units were opened in the region of Campania until the following year, so these beds were all that were available to meet the acute psychiatric needs for a population of about 5·3 million (0·007 beds per 1000, or 1 per 135000 inhabitants).

A number of authors (e.g. De Salvia & Crepet 1982, Lacey, 1984) have drawn attention to regional inequalities in the implementation of the psychiatric reform. The 1984 CENSIS survey found tenfold variation (between the regions with the best and worst provision) in the provision of general hospital psychiatric beds, catchment-area based community psychiatric services, day hospitals and hostels. In each case, the north/central were better provided for than the southern regions. It should be noted, however, that this state of affairs is not confined to the post-reform services, since a similar pattern was found by Tansella *et al.* (1987) for mental hospital beds in 1963 (the year of peak provision).

DATA RELEVANT TO FUNCTION

As McCarthy (1985) has observed, there are essentially three styles of psychiatric service in Italy. One style is exemplified in those districts, predominantly in the south, which have managed to ignore the law. Another pattern is that in which there has been, and still is, a slow transfer from psychiatric hospital to community-based care. Less commonly, there are districts where comprehensive community services have been developing for some time, and where the reform can be regarded as having been fully implemented. It has been argued (Tansella & De Salvia, 1986) that it is only in these services that an evaluation of the function, or the 'quality', of the Italian psychiatric reform is possible.

Three of these services have psychiatric case registers modelled on the Camberwell pattern. These are Lomest (Torre *et al.* 1982; Torre & Marinoni, 1985), South-Verona (Tansella *et al.* 1984) and Portogruaro (De Salvia, 1984). Each service provides in-patient (general hospital), out-patient and community care (Torre *et al.* 1982; De Salvia & Tansella, 1985), while in the organization of the latter two, much effort has been directed towards ensuring therapeutic continuity, long-term support and care for patients and their families, as well as integration between different kinds of intervention (De Salvia, 1980; Faccincani *et al.* 1985; Zimmermann-Tansella *et al.* 1985; Burti *et al.* 1986).

Three major findings emerge from the many studies of these case registers. First, they confirm that the stated community orientation of these services has been translated into practice. For example, nearly 85% of the patients treated in the Portogruaro psychiatric service in 1984 were managed exclusively in the community, and the mean not-in-patient/in-patient (not-IP/IP) ratios for the period 1980–4 were 4·0, 2·4 and 5·8 for the Lomest, South-Verona and Portogruaro registers respectively (Tansella *et al.* 1987). Furthermore, the same data demonstrate that, while admission rates have remained low and relatively constant, out-patient and day-patient attendances and domiciliary visits have increased substantially in recent years.

Secondly, the case register data have yielded little evidence to suggest an accumulation of 'new long-stay' in-patients. The proportion of in-patients accounted for by long-stay patients has decreased substantially in South-Verona and Portogruaro, and in the latter service no 'new long-stay' patients at all have been noted since 31. xii. 78 (Tansella *et al.* 1987). However, a substantial number of patients have 'graduated' to long-term community psychiatric care since the reform, and there is evidence that, at least in South-Verona, their clinical and sociodemographic characteristics are very similar to those of 'old long-stay' patients in the mental hospital (Mignolli *et al.* 1984).

Thirdly, compulsory admissions to hospital (which, since 1978, must be to a general hospital psychiatric bed) have decreased substantially since the reform: in 1984, the rate for South-Verona

was 4·8/100000 adult population, while no compulsory admissions at all took place in Portogruaro in that year (Tansella *et al.* 1987).

It appears, therefore, that *in places where the reform has been properly implemented*, the Italian model of community care without mental hospitals is able to cope with the problems presented by the whole range of psychiatric patients resident in the catchment area.

FUTURE TRENDS

Many proposals for modifying Law 180 have been presented for discussion in the Italian Parliament by political parties representing a wide spectrum of opinion, from Christian Democrat to Communist. It has been suggested that mental hospitals should again admit long-stay (psychiatric and non-psychiatric) patients, and that patients whose compulsory admission exceeds 60 days should be transferred to a mental hospital. Other proposals emphasize the need to continue to forbid admissions to mental hospitals, while suggesting that more general hospital units and community facilities (including day hospitals and sheltered accommodation for long-term patients) should be developed, and that staffing levels should be increased.

Most enlightened professionals and planners are now convinced that Law 180 must be amended (but without modifying the principle), in order to provide for more adequate development of community structures and services, to correct regional heterogeneity, perhaps by the introduction of sanctions on local authorities for non-compliance.

IMPLICATIONS OF THE ITALIAN PSYCHIATRIC REFORM FOR THE ORGANIZATION OF PSYCHIATRIC SERVICES ELSEWHERE

There is in many countries a trend of deinstitutionalization and increasing community psychiatric care. The organization of services varies widely from country to country but, nonetheless, there are aspects of the Italian psychiatric reform which we believe have general implications for the organization of community psychiatry. Three will be discussed here.

First, the Italian experience confirms that the transition from a service which is predominantly hospital-based to one which is predominantly extra-mural cannot adequately be accomplished simply by closing mental hospitals (Bennett & Morris, 1983; British Psychological Society, 1984; Gloag, 1985). It is clear that appropriate alternative structures must be provided, and this requires adequate time for planning and implementation.

Secondly, commitment is necessary. While the efficient functioning of a community-based service requires commitment from the individuals running the service, the adequate provision of service structures requires political and administrative commitment. Such commitment to the psychiatric reform is lacking in parts of Italy and, as indicated above, this is largely responsible for the unacceptably high variation in service indices between the regions. Many governments include a stated commitment to community psychiatric care within their health policy: this is certainly the case in Great Britain (Hunt, 1985; Trumpington, 1985). The problem is, however, that 'community care is not – and never will be – a cheap solution. Indeed, if it is to be effective, investment will have to be made in buildings, staff and backup facilities' (*BMJ*, 1985).

Thus, whether political commitment to a policy of community care extends to underwriting its implementation is another matter. As far as Britain is concerned, Wilkinson (1985) noted that many participants at a joint Royal College of Psychiatrists/DHSS conference on mental health service planning 'clearly doubted the ability of the NHS to provide sufficient resources to fund mental health services that would be adequate during the transition and establishment of community care, bearing in mind the need, at the very least, to maintain the existing, unsatisfactory levels of provision and standards of clinical care'.

Thirdly, monitoring and evaluation are important aspects of change: planning and evaluation should go hand in hand, and evaluation should, wherever possible, have an epidemiological basis (Wing & Hailey, 1972; Wing, 1986). Until recently, there was no tradition of epidemiological and

evaluative studies in Italy: consequently, the reform was largely planned and implemented without adequate evaluation (although, as indicated earlier, evaluative studies of the reform are becoming increasingly common). As Wing (1986) noted, 'it is essential that multidisciplinary (including economic and administrative as well as clinical and social) evaluation be undertaken at a local level and on a scale hitherto not considered. This is not simply a matter for central government departments, but for regional and district health and local government authorities which, hitherto, have not been very active in this field. Only in this way will it be possible, over a relatively brief period of time, to meet the challenge'.

Finally, it should be noted that countries in which there exists a functioning and well-developed system of primary medical care are at a distinct advantage with regard to the provision of community psychiatric care. As the House of Commons Social Services Committee (1985) noted, 'community care for the [adult mentally ill] depends to a large extent on the continuing capacity of GPs to provide primary medical care to mentally disabled people'. There is evidence (summarized by Wilkinson *et al.* 1985) that the vast majority of chronically mentally ill people attend primary care doctors, and that these play a crucial role in dealing with crises and relapses, as well as in routine medical care. Thus, whatever future plans are made for the structure or function of the specialist psychiatric services, the currently neglected role of the general medical practitioner should be borne in mind. In this regard, it is worth emphasizing one of the recommendations of the Social Services Committee: 'greater understanding and encouragement of the GP's role in the management of mental illness on the part of hospital psychiatrists would be welcome... the training of GPs in psychiatry (should be reviewed)... with a view to ensuring that GPs are better equipped to provide general medical services to mentally disabled people'.

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The work which forms the basis of this editorial was supported by the Consiglio Nazionale delle Ricerche (CNR, Rome), Progetto Finalizzato Medicina Preventiva e Riabilitativa 1982–1987, contract no. 85.00786.56, and by the Ministero della Pubblica Istruzione (MPI, Rome). It was conducted during the appointment of P.W. as Visiting Professor of Psychological Medicine, Cattedra di Psicologia Medica, Verona.

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