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# Foreign report

## Towards an implementation of the Italian model of community psychiatry

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The Italian Reform Act (Law 180) has been considered one of the most revolutionary Mental Health Acts in Western countries and has been the subject of considerable attention since its promulgation in May 1978. Interest in the Italian model of community psychiatry has been reflected in the number of articles, special supplements and letters, published in noteworthy European and American journals. However, for a better understanding of the meaning of Law 180 (now part of Law 833 concerning general health measures) the political and sociocultural climate surrounding the enactment of the Italian Mental Health Act should be considered.

From the early 1970s, Professor Franco Basaglia, medical director at Gorizia and Trieste mental hospitals in the north-eastern part of Italy, developed an innovative model of community psychiatry which was supported by left-wing political parties, student organisations and the general public in the context of the battle for civil rights. In 1977, a petition called by the Radical Party to repeal articles of the 1904 Mental Health Act, gained 700,000 signatures and on 13 May 1978 the Italian Parliament quickly passed Law 180 to avoid the likely political vacuum that a public consultation would have created. Finally, Law 180 became part of a national Health Care Reform (Law 833) which set up a National Health Service and established catchment areas (Local Health Units) with a population of 50,000 to 200,000 inhabitants.

Briefly, Law 180 ('Act on voluntary and compulsory examinations and treatments') stated:

(a) the prohibition of new first admissions to mental hospitals after May 1978 and no admission at all after December 1981 (the 'closing down' of the mental hospitals)
(b) the focus of psychiatric intervention on community based services such as day hospitals, crisis intervention centres, sheltered accommodation and family homes
(c) the 'continuity' of care with the integration of intramural and extramural services coordinated by members of the same psychiatric team
(d) the authorisation of compulsory admission within the general hospital in psychiatric wards of up to 15 beds on the basis of two medical proposals and with the prescription of the mayor
(e) the above statement to be national guidelines but with practical implementation given to regional and local authorities.

As Tansella & Williams (1987) observed, the debate that followed the new legislation should be reconsidered from two different points of view: whether the reform has been adequately implemented and, where Law 180 has been applied in terms of provision of premises, how well the reform worked.

In December 1984, data from an investigation by Censis (an independent research agency) on behalf of the Minister of Health showed an inadequate and insufficient implementation of new psychiatric services and a variable application of Law 180 between the north, central, and southern regions. In fact, 53% of psychiatric district services were concentrated in the northern regions, 20% in the central and 27% in the southern regions. At the time of the census, there were 1399 psychiatric services, 48% of which were composed by district services (mental health centres), 21% by intermediate, residential and semi-residential premises, 17% by psychiatric units within the general hospital, and 14% by pre-reform traditional psychiatric services such as mental hospitals and university departments of psychiatry.

The mental health centres showed an average of one service per 84,688 inhabitants instead of the expected optimal average of one per 100,000 population. Furthermore, 132 district services (20%) were not set up within the local health services (100 out of 132 mental health centres were not set up in southern regions) and only 32 out of 100 district services showed a good standard in service provisions.

As far as psychiatric wards in general hospitals were concerned, there were 236 with an average of 5.4 beds per 100,000 population in respect of an optimal average of ten beds per 100,000 population. In addition, 36,700 in-patients were still found in mental hospitals, the majority affected by chronic illnesses and with no rehabilitative programmes planned. Finally, only 11 out of 696 local health sanitary units were found able to provide the whole range of services while 'integration' of intramural and extramural services was hardly provided as shown by the evidence that only 52% of the district services personnel admitted to exchanging information with regard to patients' long-term therapeutic and rehabilitative programmes.

Since 1984, there have been no national epidemiological data, but local and regional evaluative studies have shown little improvement in the above numbers. Despite this general negative trend, there is evidence of districts such as South Verona, Portogruaro, Arezzo, Perugia, and Trieste where Law 180 has been fully implemented. In these districts (predominantly in the north central regions of Italy) the majority of the patients are treated in the community with a decrease in compulsory admissions and with an increased use of out-patient facilities. For example, the 1984 case register in Portogruaro showed that 85% of psychiatric patients were treated exclusively in the community with a mean out-patient in-patient ratio of 2:4 in the period 1980–1984. A similar figure has been found in South Verona and a 1984 WHO report confirmed the effectiveness of the 'new' system of care.

This review of the working of Law 180 suggests some conclusions. First, the new legislation has not been applied in most parts of Italy because of non-implementation at a local and regional level. However, it must be noticed that there are centres where the Reform, modelled on the guidelines of the World Health Organization, has been fully implemented and the legislation shown to be an efficient and innovative scheme for the organisation of psychiatric services. Second, no specific training or skills has been provided to personnel at the time of the legislative change from mental hospitals toward a 'new approach' based on community psychiatry. It is therefore not surprising that Law 180 found opposition to effective application in previous established psychiatric and nursing teams. Third, the lack or delay in long-term service provision in most out-patient psychiatric facilities has caused an unbearable burden for the families of mentally ill patients; in fact, a recent investigation demonstrated that 95% of the families had a 'negative' experience of the assistance provided to relatives in the National Health Service.

In recent years, criticism about Law 180 by professionals and patients' family associations has created a basis for discussion among the general public and a number of proposals in the Italian Parliament. The 1990 proposal and the related Mental Health Project supported by the current Minister of Health, Francesco De Lorenzo, has reached consensus within a wide spectrum of political parties and should ameliorate some of the structural flaws of Law 180, without a modification of its basic concepts. The Law proposal will be aimed at providing a more adequate development of community services, correcting dysfunctions and unevenness on a regional basis, introducing sanctions on local authorities for non-compliance, and support for families of chronically ill patients.

The focus of the five articles of the Law proposal is on the procedures for compulsory admission. Mandatory admission will be prescribed in the psychiatric wards, and also in the community services, and the doctor will provide it as usual but no mayor's ratification has to be waited for when urgent therapeutic measures are needed. Therefore, the psychiatrist will be legally protected in the interval between hospital validation and the mayor's order.

In addition, the Mental Health Project clarifies the practical and structural aspects of mental health services, the optimal demographic ratio for each service and the financial support for the period 1991–1993.

It has established a Department of Mental Health (DMH) aimed at coordinating district, hospital and community based psychiatric services. The DMH will be composed of:

(a) mental hygiene centres
(b) community care facilities
(c) psychiatric wards within the general hospital
(d) emergency service.

The Mental Hygiene Centre (MHC) will coordinate the community based activities providing out-patient and domiciliary services and therapeutic, pharmacological, and therapeutic programmes. In addition, a specific support and information service for patients' families will be developed. The MHC will be open for at least 12 hours a day, six days a week with an estimated average of one centre per 100,000 population.

Community care facilities, one of the distinctive features of the Italian model of community psychiatry, are now clearly ordered in day hospitals, residency for brief and long-term assistance, and sheltered accommodation for chronic patients dismissed from the old mental hospitals. Day hospitals will be composed of up to 20 beds (one bed per 100,000 population) with out-patient facilities and rehabilitative premises. Residencies will make provision for brief and long-term assistance and will integrate pharmacological, psychotherapeutic, and rehabilitative treatments. Sheltered accommodation of up to 20 beds will use the premises of the old mental hospitals and will be aimed at patients requiring long-term treatment because of lack of familial support. They are conceived as 'exhaustion' structures with no new admissions and with progressive dismantling according to the decreasing number of chronic patients.

Psychiatric wards of up to 16 beds within the general hospital will receive compulsory and voluntary admissions while an attached emergency psychiatric service of up to four beds will remain open 24 hours a day, seven days a week, and will be staffed by psychiatric ward personnel. The academic departments of psychiatry will be involved in the Mental Health Project and have the responsibility of a DMH and at least three of the above mentioned facilities.

Finally, it proposed the establishment of a Permanent Psychiatric College, directed by the Minister of Health and composed of experts of the Institute of Health and National Research Council together with members of family associations. The aim of the College will be the evaluation of proposals, investigations and programmes concerning the national situation of premises and personnel staffing. In addition, a special epidemiological office will examine data coming from local and regional units.

In conclusion, Law 180 represented an advanced model of community psychiatry that remains up-to-date in the '90s, according to a number of recommendations expressed by the World Health Organization with regard to rights of patients and alternative treatments. The 1990 Law Proposal should provide the basis for a better evaluation of the validity of the basic concepts of the Italian Psychiatric Reform, which in turn could be of value for psychiatric services in a wider international context.

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