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SPECIAL ARTICLE

Forty years of the Law 180: the aspirations of a great reform, its successes and continuing need

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Aim. Italy pioneered deinstitutionalisation over the past 60 years and enforced a famous mental health (MH) reform law in 1978. Deinstitutionalisation has been completed with the very closure of all psychiatric hospitals over two decades.

Methods. After 40 years of implementation, this article presents the main achievements and challenges of the Italian MH reform law, including its long-term effect and impact in Italy and abroad.

Results. The Legislation of 1978 was based on the discovery of rights as a key tool in mental healthcare. At the climax of crisis of psychiatric hospitals as total institutions in this country, through the new community-based system of care, it has fostered the lowest rate of involuntary care and gave back the full citizenship to people with MH disorders. This act was also part of a social movement for expanding civil and social rights, and a promise of a true paradigm shift not only in psychiatry, but also in the way of providing an adequate welfare community for all citizens. According to the WHO, the Italian city of Trieste, together with its region, is a practical example of how the Italian movement achieved deinstitutionalisation, intended as a complex process resulting in the gradual relocation of the economic and human resources and subsequent creation of 24 h services together with the development of social inclusion programmes.

Conclusions. Even if the great principles of the Italian reform law were anticipatory (e.g., the UN Convention on Rights of Persons with Disabilities – CRPD), the law application has been poorly provided with resources and did not follow those avant-garde experiences as models. Limitations are evident today especially at the organisational levels, such as services capable to take up the challenge and transforming the field, left free from the imprint of total institutions. These endemic critical aspects concerning to implementation policies, together with the financial crisis of the Italian healthcare system, must be taken into consideration for a re-launch of this historical law. The rights-based approach opened by the Law 180 should now take into consideration the new legal situation caused by the CRPD worldwide in the area of individuals' human rights, especially about the issue of legal capacity and related involuntary care.

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Introduction: for a critical analysis

'Legislation that protects vulnerable citizens (including people with mental disorders) reflects a society that respects and cares for its people. Progressive legislation can be an effective tool to promote access to mental health care as well as to promote and protect the rights of persons with mental disorders.' (WHO, 2005).

Italy pioneered deinstitutionalisation in the 1960s and the 1970s and enforced a famous mental health (MH) reform law in 1978, later associated with the name of Franco Basaglia. The Law 180 cannot be simplistically identified with that movement. It was not only an important achievement for Italy but also a great move forward, since it was the first Act worldwide to abolish the psychiatric hospital and to give back the full rights of citizenship to people with MH disorders, with a symbolic value for psychiatric reforms in many countries, and till today has been defended or attacked, accused or emphasised.

A lot has been written from the historical point of view (Micheli, 2013; Babini, 2014; Foot, 2015; Pulino, 2017). From the point of view of its impact and application and enforcement, several articles in the international literature has been issued also recently, accounting on the current situation in Italy (Lora, 2009; Ferrannini *et al.* 2014; Fioritti & Amaddeo, 2014).

If it is now the time, after 40 years, to reconsider the Law 180, the analysis should encompass successes and/or failures of its implementation as a broad system change, with its impact on the culture, mentality, social representation of mental illness and even on the rights of all marginalised people and oppressed minorities

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far beyond Italian borders. It expanded from Italy to several countries that took it as an example, especially in Europe and Latin America (Toresini & Mezzina, 2010). For instance, reform laws in Spain (1985) (Aparicio Basauri & Sanchez Gutierrez, 2002; López, 2004; Aparicio Basauri, 2010), in Brazil (2001) and in Argentina (2010) are particularly inspired by that model (Rosen *et al.* 2012, 2014).

De-institutionalisation has been completed in Italy with the closure of all psychiatric hospitals in two decades. Learning from the experience of the historical and decisive anti-institutional movement in this country is fundamental, especially to understand to what extent it is possible to change the nature of psychiatry towards respectful care.

In this paper, we will attempt to consider at a glance the multifaceted aspects of this legislation:

- As a new set of norms respecting human rights (the normative character);
- As the climax of a crisis of psychiatric hospital as an institution and the rising of community-based mental healthcare (the policy character);
- As a promise of a true paradigm shift in psychiatry, a new way of thinking about people with psychiatric issues, that is a model for all countries, with all its cultural shifts and implications (the seminal character);
- As an expression of a social and, to some extent, political movement for expanding civil and social rights of vulnerable groups (the citizenship character).

The Law 180 belongs to a group of normative acts that, over a decade, deeply affect the life of the country, innovating the ethical and social relations and the condition of the minorities of disadvantaged people, but also expanding the civil rights (i.e., abortion, divorce, the statute of workers). Democratic mobilisation and participation of civil society was very important in the 1970s, but the reform was supported by the prominent role of family national organisations from the 1990s till today.

The Law 180 is not aimed at a special category of people who are predefined, but to all citizens who can have an MH problem. The issue of 'separate *v.* integrated legislation on MH' (WHO, 2005) has been addressed by Italy incorporating the Law 180 into the National Health Service (NHS) general health law at the end of the same year.

Basic principles and constitutional value

The Law 180 sets principles and norms, but also provides some ground breaking policy indications and prescriptions such as:

(1) the tutelage of mental health is declared to be in the community;
(2) current psychiatric hospitals must be closed;
(3) no new psychiatric hospitals can be built up anymore;
(4) coercion is allowed and only for health purposes.

The WHO resource book on legislation acknowledged the innovation of the Law 180: 'Legislation may require that admission to hospital be allowed only if it can be shown that community-based treatment options are not feasible or have failed'. For example, as early as 1978, Italy legislated that '… the proposal for compulsory health treatment can envisage hospitalisation care only if mental disturbances are such as to require urgent therapeutic intervention, if these interventions are not accepted by the patient, and if there are not the conditions and the circumstances for taking immediate and timely health care measures outside the hospital' (WHO, 2005).

In the Law 180, the reason for a very limited use of involuntary care is linked to the severity of the conditions and the denial of care on the part of the person. Dangerousness is not anymore mentioned as the reason for it, so there is no power assigned to the judiciary system. The overcoming of the architrave of the previous legislation, which combined mental illness with social danger for oneself or others, and of being a public scandal, led to a radical change in the system of involuntary treatments.

The healthcare system (e.g., at least one of the two physicians involved in the proposal must be a public health doctor) is obliged to search for a consent and in this case the involuntary treatment (TSO, trattamento sanitario obbligatorio) has to be immediately converted into a voluntary one. Searching for voluntary care is a clear mandatory rule, and this is a recognition of contractual power to the person. Involuntary treatments are time limited, and they do not suspend all constitutional rights including freedom (obligation of care, not detention or seclusion). The short-limited time frame guarantees a totally different career for the patients, without long-term institutionalisation. For WHO, rights of users of MH services must be ensured: confidentiality, access to information, rights and conditions in MH facilities, free and unrestricted communication with the outside world (including receiving visits, letters and other communications from friends, family and others, etc.) (WHO, 2005). In the Law 180, these aspects are clearly focused, like the right to communication and right to appeal, as well as the role of the 'tutelary judge' who is entitled to protect the rights of the person, checking the consistency of the proposal of involuntary treatment according to the law's criteria and can suspend it (FRA, 2012).

A famous quote of Norberto Bobbio, one of the fathers of the Italian Republican Constitution of 1948,

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made it as a true example of reform because of its capacity of transforming the society. It recognised a fundamental value, that is freedom of those who were considered not to have the right to be liberated – the recognition to have the right to be free as the others (Pulino, 2017). The Law 180 has been rooted in what the Italian Constitution of 1948 anticipated: 'The Republic recognises and guarantees the inviolable rights of man, both as an individual and in social formations where his personality is turned' (art 2 Constitution); 'No health treatment can be mandatory except by law. Practices harmful to human dignity are not permitted' (art 32 Constitution). Basaglia spoke of the suspension of individual rights in the 'anomia' of the asylum (Basaglia, 1987a, b), where there are no constitutional rules, which is a prelude to the irreversible loss of rights (Piccione, 2013).

Implementing Article 32 of the Constitution, the return of the dignity of the person with a mental disorder is achieved precisely through the idea that he has to be determined to care and that the public health system must always offer conditions of assistance adaptable to its individuality and its needs as individual. The mental disorder does not undermine the right to self-determination (Piccione, 2013).

Towards health and welfare integration for mental healthcare

The legislative abolition of the false equation, mental disorder and dangerousness raises the issue of psychiatric assistance on the front of social rights, of the use of welfare services aimed at guaranteeing the fundamental right to MH, protected by the Constitution. The tutelage of mental health privileges and prevention is included in general health services to eliminate any form of discrimination and segregation and to favour recovery and social reintegration of people with mental disorders (art 2, comma 2, letter g) of Law 833).

Thus, there is a need to ensure employment opportunities and priority in state housing schemes and facilities, in getting disability pensions, in the exercise of the right to vote, to marry, to have children, to own property, to work and employment, to education, to freedom of movement and choice of residence, to health, to a fair trial and due process of law, to sign cheques and engage in other financial transactions, etc. (WHO, 2005).

The seminal character of the Law 180 implied some corollaries: other laws to complete a welfare state provision and the social inclusion or integration of people with severe mental illness (law of social co-operatives, 1992; law of supported administrator, 2004; law of integration of welfare and health care services).

From this point, the Italian process is a lead. A decisive and indispensable precondition is that the renewal of welfare systems be closely linked to these changes and an effort to coordinate related policies and governance with a universal access to all citizens. The focus is on full citizenship for social rights for the weak and vulnerable persons who leave total institutions and who, due to psychiatric disability, lack social opportunities and equal access. Italy enforced a law in 2001 (n. 328) aimed at creating an integrated health and welfare service system. Some years later (2005), the EU Green Book (followed by the European Pact for Mental Health and Wellbeing) stressed the need to focus on the more vulnerable social groups for social inclusion (Commission of the European Community, 2005).

Italy was the first country in the world to mandate halting all admissions to mental hospitals. Even if this is a framework law for healthcare policies in this field, it would be wrong to attribute the status of the MH services in Italy to the law. It stands on this side and goes well beyond this. 'Mental health law and mental health policy are closely related. Mental health law can provide a legal framework for policy development and then influence the development and implementation of policy, while the reverse is similarly true' (WHO, 2005).

It is well know that many problems were created by a lack of policy implementation at many levels including technical ones. First of all, no dedicated funds were established. Moreover, despite two national plans for MH (1994–1996 and 1998–2000), there was a lack of proper governance in a de-centralised regional-based health service. Eventually the death of all psychiatric hospitals occurred 21 years later only under the threats of cutting expenditures for the whole health systems if a single region would not provide a plan for their closure (1996–1999).

The Italian way to deinstitutionalisation

Alongside the closure of asylums, we can identify positive outcomes that are relevant for our discussion in the transition to a fully community-based mental healthcare (Fioritti & Amaddeo, 2014). One of the main indicators were involuntary treatments that dropped dramatically after 1978 as an immediate effect of the Law 180 and have sustained the lowest ratio in Europe (17/100 000 in 2015) and the shortest duration (10 days). Moreover we can summarise this process as follows:

(a) Reconversion of budget: in Trieste for instance, the total cost of the new MH network does not exceed the former MH budget and nowadays is it about 39% of the above, but it reaches 4.1% of health expenditure (Mezzina, 2014, 2016).

On a national scale, even though no precise data are available, the current cost of psychiatry does not

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exceed so far 3.5% of the Italian NHS cost, ranging from 6.5 to 2.1% according to different regions, which demonstrate a loss of money for MH in general (Starace *et al.* 2017).

(b) Role and feature of the Community Mental Health Centre (CMHC)

The problem of the CMHC looks ever more to be the central practical–theoretical point in the pursuance of the law. On one hand, the original Italian concept of the CMHC was the standpoint of a MH department, as the main or the only point of reference for all psychiatric requirements of the entire catchment areas. This position can allow and even oblige the CMHC to conduct a continual cycle check on its own effectiveness on overall pathways of care in the community it serves. Inversely, if the CMHC is conceived as a simple outpatient clinic, that means accepting an unavoidably subordinate situation in terms of structure and work similar to the hospital-based services (SPDC, servizi psichiatrici di diagnosi e cura) and private hospitals (De Girolamo *et al.* 2007). In the presence of weak and not focused community-based services, the system is often dysfunctional and produces 'residuals' who stick in long-term residential care, even if this happens in the community settings (Rosen *et al.* 2012, 2014).

(c) Mainstreaming

Each CMHC has to be linked to basic medical care, social services, services for the elderly, co-ordinated by the 'healthcare districts,' but this kind of mainstreaming does not apply easily because of wide regional variations, and when happened seemed to give priority to the treatment of common mental disorders (Lora, 2009). Mainstreaming MH in general healthcare has been interpreted according to several different models, e.g., healthcare district centres, 'Case della Salute' integrating general practitioners, etc. (Berardi *et al.* 2014)

(d) Rehabilitation facilities and supported housing

Deinstitutionalisation was mainly implemented through a high number of community residential programmes such as small-scale group homes, often 24 h run and mainly managed by non-governmental organisations (NGOs) who still represent in many areas the most expensive investment (De Girolamo *et al.* 2002; Picardi *et al.* 2014). Sheltered community-based homes proved to be of great importance to more than 17 000 places at the end of the 1990s towards about 30.000 (estimated) in 2017. These are mainly group apartments for about 8–10 people who are attended by nurses or by NGOs (co-operatives, volunteer organisations). It is anyway noteworthy that in Italy, rehabilitation and reintegration of former long-term patients in transitional community residential settings is more extensive than in any other country.

(e) Citizenship and recovery

For people with MH problems, the issue of equality and the right of being cared for includes a complete system of resources and provision intended for social reintegration and an actual citizenship (Mezzina, *et al.* 2006a, b). Integrated social co-operatives were developed as one of the most outstanding results of the change. The first one in Trieste started as a practical response to exploitation of MH inpatients in cleaning the asylum, ensuring a real pay at trade union rates. More than 4500 cooperatives are now operating in the country. Among them, 'B'-type co-ops, namely for work placement, include at least 30% disabled service users and get a tax break to help them sustain a viable business (Rotelli *et al.* 1994; Leff & Warner, 2006; Fioritti *et al.* 2014). They strive to be competitive in the market, involving people with mental illness as service users, people with 'social disadvantage' as well as other citizens, in work activities that include agriculture, building, cleaning, tailoring, hotel operation, restaurant, home catering businesses, etc. Social cooperatives represent the most important resource (80%) for people with severe MH issues (49% with psychosis) to be employed as shown by a national survey (Bracco *et al.* 2013). Moreover, self- and mutual help groups, peer support and user–carer operated services, and MH associations have grown everywhere in the country, embracing a recovery vision, over the past 30 years (Mezzina *et al.* 1992) and advocating for their own rights (Javed & Amering, 2016).

(f) Public cultural change

Social acceptance of the law and a general decrease of stigma attached to psychiatry mark a series of fundamental changes in public attitudes with no way back. Carer associations as UNASAM, as well as professional ones (e.g., the Society of Italian Psychiatry), for many years claim for better community services rather than for a new law, even if more than 30 bills have been presented in these 25 years. Research demonstrated a reduced family burden than in other European countries (Magliano *et al.* 2002). The change in the mentality, due to the closure of institutions, is an achieved goal.

(g) Forensic hospitals

This sector, not considered by the Law 180, has been included finally in a new phase of de-institutionalisation (Rosen *et al.* 2014). On 31 March 2015, the law n. 81 declared the closure of all six forensic hospitals (OPG, ospedali psichiatrici giudiziari), replaced by small (<20 beds) regional units

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linked to MH departments. This process resulted in significant improvements, such as closure of all six forensic hospitals, the decrease in the number of forensic beds from about 1500 to 604 (of which 567 occupied). The integration of those smaller units in MH departments, linked to community MH services and the rapid turnover (457 persons discharged in 18 months). This has been defined as a 'second – gentle – revolution' after the closure of all psychiatric hospitals (Corleone, 2017).

The Trieste model

Trieste is an internationally known experience that started in 1971 under the direction of the great figure of Franco Basaglia, and resulted in the first closure of a psychiatric hospital in Europe in 1980 (Bennett, 1985; Dell'Acqua & Cogliati Dezza, 1986; Rotelli, 1988; Dell'Acqua, 2010). Moreover, it was also a process of change of thinking, practice and services.

Trieste showed a different way for an innovative community MH, which has moved from a narrow clinical model based on the illness and its treatment to a wider concept that involves the whole person and the social fabric (The Economist Intelligence Unit, 2014; Zero Project, 2015). The organisation is based on 24 h CMHCs with a few community beds in each of them, a very small general hospital unit, a high number of social cooperatives and many innovative programmes in the area of recovery and social inclusion. The MH department is recognised as a WHO collaborating centre for 30 years and it is considered as a sustainable model for service development – even in a context of economic crisis, because of its clear demonstration of cost-effectiveness (Mezzina, 2010, 2014, 2016). According to the WHO (WHO, 2001), Trieste, now together with its region, is one of the clearest examples of how the Italian movement achieved deinstitutionalisation, intended as a complex process 'from within' a psychiatric hospital resulting in the gradual relocation of its economic and human resources, and the creation of 24 h community-based services together with the development of social inclusion programmes (Rotelli *et al.* 1986).

The organisation and philosophy of these 24 h CMHCs is based on the principles of: (1) non-selection of demand (i.e., not based on particular diagnoses, severity thresholds or other exclusion criteria); (2) non-hospitalisation; (3) service flexibility and mobility; (4) the involvement of multiple comprehensive resources, such as a wide range of welfare provisions, in the therapeutic and support programmes (Mezzina & Vidoni, 1995; Mezzina & Johnson, 2008) and, moreover, (5) continuity instead of transitions in care (Segal, 2004).

Presently in Trieste, 94% of the MH budget is spent in the community (18% directly to personalised and budgeted packages of care), with only 6% of the budget going to a six-bed general hospital-based service that acts as an emergency first aid station at night.

In Trieste and also the Friuli-Venezia region:

- The departments of MH include comprehensive integrated CMHCs, 17 out of 21 are open 24/7, with 6–8 beds each (populations 50–80 000), including mobile teams, and a minimum of beds in general hospital acute units (SPDC) (n = 30 beds in total).
- There is a clear shift from residential facilities to supported housing and transitional housing, towards independent living accommodations (Ridente & Mezzina, 2016).
- Mechanical restraints have been abolished in health and social care, including nursing homes and general hospitals.
- Involuntary treatments show the lowest rate in Italy, and about 40% of them are managed in CMHCs with open doors.
- The new forensic system spread the ten beds into an existing daycare service and two other residential facilities in three areas of the region. This is to facilitate the integration in the service network (of MH departments but also the welfare and third sectors) and the inclusion in the community. They are managed *de facto* with an open door policy.
- The community development programme of 'micro-areas' launched 15 years ago by healthcare agencies (in Trieste and elsewhere) is a proactive approach to identify small neighbourhoods (1000–1500 inhabitants), to detect needs of care and support, prevent hospitalisation and institutionalisation, integrate services around the whole person needs through a whole community approach. Hard and soft indicators show positive outcomes.
- The social coops system is highly developed and offers real work to many people (more than 2000 members in the region).

The promises of the Law 180, its judgement and the international debate today

Basaglia pointed out the insertion into the legislation of a civil and constitutional element that is the recognition of human rights (Basaglia, 1987c). In terms of system change, the recognition of WHO was striking, especially regarding to Trieste achievements (WHO, 2001). The Helsinki Declaration and Action Plan (WHO European Ministerial Conference on Mental Health, 2005) also said that community services should provide care in living places, be accessible 24 h a day, 7 days a week. They should be integrated, 'comprehensive' and efficient, and

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offer a wide range of interventions, from promotion to prevention, from care to 'recovery'. It also explicitly stated that there is no longer any place in modern society for large institutions.

With the end of the asylum, the right to MH, precisely because it aims to emancipate the person from need, constitutes the precondition for the exercise of civil liberties. For Basaglia, even if this was the result of a political compromise, it was also the practical result of what has been affirmed in years of struggle, and as such can be considered a success (Basaglia, 1982).

The practices of deinstitutionalisation have gone through very broad institutional areas, from medicine to school, to prisons, to shelters for the elderly, to institutions for minors and for people with disabilities and, more generally, to the entire ambit of welfare policies.

Other steps of these years have been important in terms of law:

- The resolution of February 2000, adopted by the National Bioethics Committee, which recognises the singularity, dignity and right of the person in all the steps of the treatment process as the main actor (Comitato Nazionale per la Bioetica, 2000).
- The two most recent resolutions, relating to the legal issue of biomechanical restraint (Comitato Nazionale per la Bioetica, 2015), which finally begins to grasp the profile of absolute illegality, and that of September 2017 which mainly concerns the new scenario determined by the overcoming of the OPG, and innovative contents made by the Convention on the Rights of Persons with Disabilities (CRPD) (Comitato Nazionale per la Bioetica, 2017).

The Law 180 and CRPD

In many ways, the reform law anticipated the CRPD, issued by UN in 2006. The fundamental right to health care, including MH care, is highlighted in a number of international covenants and standards (WHO, 2005). Chiefly, the right to health is now also included in the promotion and protection of all human rights, civil, political, economic, social and cultural rights, including the right to personal, social, economic, cultural and political development (United Nations, 2017).

Even the WHO Resource Book has been withdrawn because of the CRPD, as far as it legitimated involuntary treatment, no coercion in care is now admitted by the Committee of CRPD (2015) and this is a clear direction also for WHO Quality Rights Programme (WHO, 2017). In the Law 180, involuntary treatments are made possible through a substitute decision-making, seen as a denial of legal capacity.

The CRPD is based on substantive rights: they are imperative and non-negotiable, but they can remain abstract, unless they are connected to citizenship and participation to a society, challenging social exclusion, acting on social determinants of health (Marmot, 2005; WHO & Calouste Gulbenkian Foundation 2014) to achieve greater equity of quality and stability of home, work, income, supports (Mezzina *et al.* 2018). Sociologist Alain Touraine (Touraine, 2015) warned against exasperating the distinction between social rights, of capital importance in industrial societies, and fundamental human rights. The defence of the dignity of human beings must not be separated from the pursuit of social justice, from an active struggle against inequalities, privileges and injustices. He insisted on the central importance of the theme of dignity, because it bears in itself the direct and ethical affirmation of the law. These political, legal and social action has to be combined with our own emancipation as clinical professionals from institutional thinking and practices in MH and social care (Mezzina *et al.* 2018). However, the recognition of the political role of psychiatrists should also have been considered critically, e.g., as – 'that is officials of social consent' (Basaglia, 1987d). The recent WPA-Lancet Commission on the future of psychiatry also provides a clear, not ideological description of the main contradiction of psychiatrist as authority between human rights and prevention of violence 'that poses a constant challenge', especially after CRPD (Bhugra *et al.* 2017).

A conclusion: updating the Law 180?

The WHO has asked countries to update their legislation and policies (WHO, 2013) in line with the CRPD and other international and regional human rights instruments. (Global target 1.2: 50% of countries will have developed or updated their laws for MH in line with the international and regional human rights instruments by the year 2020.) Stakeholder collaboration is also needed: strengthening and empowerment of people with mental disorders and psychosocial disabilities and their organisations must be pursued through 'a formal role and authority to influence the process of designing, planning and implementing policies, laws and services'. From this point of view, Italy shows surprisingly a less developed awareness of the need of the self-advocacy and political voice of service users and carers.

So Italy must do that, despite the great anticipations of this historical Act, especially regarding: (a) the guarantees about self-determination and the checks of the use of involuntary treatment (including the right to appeal) that has been declared but not implemented

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in the current practice, as well as a regular, time-bound review of involuntary admissions by an independent review body (required by WHO). The debate in Europe is still in course, but no total abolishment of coercion has been declared so far (Council of Europe Parliamentary Assembly Recommendation n., 2091, 2016).

(b) The decline of services and the regional inequality, so there is a great need today to create mechanisms for the real implementation of the Law's principles and consequences that are today at risk of a late dismantling action due to passiveness and neglect on part of both technical and political levels. Even if there is presently an adequate number of community MH centres (about one centre for every 80 000 people; Ferrannini *et al.* 2014), the way they are operated remains contentious. A well-staffed and well-resourced CMHC's multidisciplinary team must be mobile, assertive and proactive to be the core of an MH department as the one-stop shop for all psychiatric requirements of its catchment areas. Unfortunately, weak and unfocused community-based services in many regions provide neither alternatives to crisis care nor long-term support and rehabilitation, and eventually produce 'residual patients' who nowadays became stuck in residential community settings. However, in some regions, the implementation of personal budgeted plans and packages of care (involving NGOs such as coops and associations) aims now at fostering discharge from residential programmes towards individual supported housing and other personal supports in the community. The national data show a trend to further reduce expenditures dedicated to mental healthcare. Recent cuts due to economic crisis are jeopardising the system, merging and closing CMHCs within a trend of centralisation towards MH departments for large catchment areas, such as a million of inhabitants in metropolitan areas. In general, the uneven level of assistance among the different regions and in the whole country, instead of decrease, seems to increase overtime (Starace *et al.* 2017).

The final report of the Parliamentary Commission on the State of the NHS, adopted in 2013, at the end of numerous visits to the MH departments, auditions of operators, family members and administrators, provided a critical assessment of the state of services that confirmed our main points: CMHCs with limited working hours, the lack of individualised and integrated psychosocial interventions, prevailing pharmacological prescriptions, no home crisis care, no attention to the family and social network; long-term 'communities' as passive containers without a rehabilitative value; the private hospitals offering an old traditional clinical approach; the appeal to the TSO as a result of lack of prevention; SPDCs disconnected, mostly closed places, with a wide use of restraint measures. In terms of governance, there are no systematic consultant and control bodies for MH, and scarce cooperation with voluntary associations. Among the proposals for improving the quality of services and care, the report suggested to develop an integrated and individualised approach sustained by an economic approach (e.g., personal budgets). A process-based rather than a facility-based approach (risking fragmentation) is thus invoked. This transformation will require to implement 24 h CMHCs, to support job training and placement, and empowerment through participation of service users (Commissione Parlamentare di Inchiesta sull'Efficacia e l'efficienza del Servizio Sanitario Nazionale, 2013). Basically, what Trieste showed to be possible.

From the beginning, the law application did not recognise those avant-garde experiences as models. Limitations are evident today especially at the organisational levels, such as services capable to take up the challenge and transforming the field, left free from the imprint of total institutions. These critical aspects concerning to implementation policies of a truly innovative system of community-based services, together with the financial crisis of the Italian healthcare system, must be taken into consideration. The arising need to reform existing legislation resulted recently in two separate bills, developed bottom-up by stakeholders (users, carers and professionals) together with the members of the Parliament, especially to update and implement the 1978 reform principles which have been not yet fully achieved.

At the end, the principle of freedom of the individual is what has been clearly affirmed through this act and its implementation (Piccione, 2013), and today we can mention 'freedom first' as a fundamental precondition of care (Muusse & van Rooijen, 2015). All of this impressive legacy, the Basaglia's anticipations and the Law 180 'revolution', is the property of the same people who have a direct experience. The main outcome of the Law 180 is the vital and living presence of people, subjects returned to have a life (IMHCN, 2015), beyond and above all changes in institutions. The normative character of a new law could not anyway replace the force of a movement. This great reform today requires further support, resources and impulse from many actors to fully realise its aspirations and be brought to its consequences. It is a paradigm shift (Mezzina, 2005), from the illness to the person, that now they can claim.

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Conflicts of interest

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Availability of data and Materials

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