From asylum-based psychiatry towards a community-based mental health that questions all policies

Giovanna Del Giudice

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I would like to thank the Minister of Health of Argentina, Carla Vizzotti, and the Director of the WHO Department of Mental Health and Substance Use, Devora Kestel, for the opportunity they have given me to speak at this esteemed gathering.

I would like to greet the ministers,

those who experience mental suffering,

and today's participants.

Today I will discuss the topic of transitioning from asylum-based psychiatry to community-based mental health that links with all policies, drawing from the experience of deinstitutionalization developed in Trieste, from the early 1970s of the last century, by Franco Basaglia and his working group, which led to the closure of the asylum and the establishment of a network of mental health services in the community. This process has given a voice, subjectivity, and rights to people who suffer from mental health conditions, whose rights were previously denied and were silenced by institutionalization.

It involved shifting the focus from mental illness (and the idea of danger it was associated with) to a view of the person in their entirety and the full range of needs, related to and integrated into the social context. It meant expanding the scope and skills from healthcare to all policies: social care, housing, education, employment, gender, development, to meet the full range of needs of individuals with mental suffering, who have regained their status as subjects with their own rights.

Even today, in various parts of the world, though qualitatively and quantitatively different in terms of social, political, economic, and cultural contexts, with differences between urban and rural areas, the predominant reference model for assisting people with mental health conditions is the custodial asylum model, which uses coercive practices and violates human rights.

On average, 2% of the healthcare budget worldwide is allocated to psychiatric care, and 70% of this goes to psychiatric hospitals.

Even today, in some parts of the world, people with severe mental health conditions risk being segregated, confined to small spaces, abandoned at the margins of communities.

People with mental health conditions represent one of the most oppressed minorities.

However, in many parts of the world, important processes of moving beyond the asylum model are underway, and transformative practices for the care of people with mental suffering are being initiated, many of which I will mention today.

The process of deinstitutionalization in Trieste, in which I have been involved from the beginning, represented a theoretical and practical challenge to the cultural, scientific, and legislative paradigms

that supported the asylum as a place of custody and segregation, deprivation of rights, generator of chronicity, and annihilation of individuals (patients and staff). Our urgent and necessary goal was its destruction (Basaglia). It also challenged psychiatry as an ideology that materializes as a reality through the asylum (Basaglia, 1979).

It was not the proposal of a new therapeutic model but the proposal of a new way of understanding and living social relationships: between the individual and the institution, between knowledge and power, between health and illness, between the individual and the collective, between individual and social realms (Rotelli).

It was a radical, complex commitment on multiple levels: it operated on the value system and paradigms underlying psychiatry, changed services for people with psychosocial disabilities, and led to a reform law, Law 180 of 1978. This new law marked the end of the asylum, it called for voluntary care being provided in the community, it ended the tendency for mental illness to be associated with social danger, and the special status being given to individuals with mental suffering, marking their entry into social citizenship.

In Italy, when Franco Basaglia took over the direction of the psychiatric hospital in Trieste in 1971, where 1,200 people were institutionalized, out of a population of 51 million inhabitants, more than 100,000 people were interned in 83 asylums. A law from 1904 declared that mentally ill people were dangerous, and after 30 days of hospitalization, these people were usually segregated and excluded from the social contract, losing their civil and political rights.

In Trieste, the dismantling of the asylum was a collective effort, starting with the abolition of containment and coercion, the opening of doors, the end of gender segregation, the questioning of power dynamics in the care relationship and institutional hierarchies, and opposition to the process that transformed natural diversity into social inequality.

It blocked the transfer of patients from acute wards to long-term care wards, interrupting “the moral career of mental illness” (Goffman). Individuals, after a period of treatment, returned to their lives, supported by asylum staff who began to work in the community.

For people with a long history of institutionalization, civil and political rights were restored, stories and relationships were reconstructed, objects, relationships, and interactions were returned and restored, enabling life in freedom, and a return to the community with the support of staff who had also been liberated from the asylum.

It should be noted that while misery and contradictions previously confined in the asylum were exported into the community, we, the staff, were present to manage and discuss them with families, neighbors, citizens, and institutions to build alliances, new cultures, and practices towards the development of a caring community, a city that cares.

In dismantling the asylum, there was an immediate shift towards a community-based approach, founded on a belief that individuals with mental suffering should be met and cared for in the community, in places of normality, through a circuit of substitute services for the asylum, based on human rights and commitment against any form of institutionalization.

The 24-hour Mental Health Center with hospitalization services was created and became the institution that, within a community service network (residential groups, psychiatric services in general hospitals, services and paths for rehabilitation and social and occupational inclusion), served as a substitute for the asylum, the institution that had been abandoned.

The Mental Health Center is open every day, it’s easily accessible and close to people's living areas, it responds to the care needs of residents in a defined area. Staffed by a multidisciplinary team, it provides outpatient and home-based services, pharmacological support, rehabilitation, family support, and community engagement. It promotes exchanges, relationships, support for daily life, interfaces with health and social services, the judicial system, labor cooperatives, associations, cultural and productive groups.

The Center has some beds for daytime and temporary nighttime care for people in crisis, in an environment permeated by the community, reducing stigma and promoting recovery.

In Trieste, the community-based mental health service network based on the 24-hour Center with hospitalization services led to the definitive closure of the asylum in 1980, a reduction in involuntary psychiatric treatments, the elimination of referrals of people with mental health conditions to the criminal justice system, and a reduction in economic and human costs, while increasing the number of people accessing care and the number and quality of care locations.

In dismantling the asylum, through the reappropriation of rights and freedom, with the return of former inmates that now had an active role in the community, even just as consumers, needs/rights that were previously hidden by the illness, violated and denied by institutionalization, began emerging.

Furthermore, working in the community shed a light on new needs, new forms of urban suffering, pockets of marginalization, individuals at risk of illness and exclusion, people who did not access minimum rights, who struggled to access services.

To address this, complex and articulated responses that involve all policies are necessary, as well as to counter the medicalization of social distress.

Mental health, intended as well-being, as the ability to choose, to self-determine, to participate in a shared project, to have a role in a community of diverse people, to engage in social exchange, to have an income, a home, a job, social relationships, and social interaction, is a fundamental human right.

This involves not only health policies and mental health professionals but all policies and the entire community.

To build community mental health in a country, in a region, in a territory, strong political engagement from national and local governments is necessary, along with a strong commitment from innovative professionals.

We have always found that significant transformations in psychiatry occur through joint action by politicians and innovative professionals, confirming that mental health action is a technical-political action that alludes to a different vision of social relationships, power relations, and a new humanism.

Therefore, both legislative and public health action is necessary to direct and regulate the transition to community mental health, to establish the shift of human and economic resources from the asylum to the community, which is so essential to overcoming this outdated model making the care of individuals in the community effective.

The involvement of all social policies, housing, gender, employment, education, development... in a theoretical and practical orientation that ensures comprehensive responses to all needs/rights, to the most vulnerable individuals with psychosocial disabilities, at risk of exclusion, to ensure their participation in active life and equality before the law, is also required.

Such intersectoral policies must include direct measures such as the promulgation of laws and regulations, specific programs and resources, and indirect measures to intervene in the cultures and social relationships of a community.

Given that these policies and measures are closely related to the specific contexts of local communities, we provide some examples, starting from our experience, in the field of housing and employment.

To respond to the need for housing for people with a history of institutionalization in psychiatric hospitals, institutionalized minors and people with disabilities, people in prisons, migrant centers, or marginalized individuals who do not meet the minimum requirements to access housing, housing policies must legally allocate reserved public housing units to these individuals to be managed in collaboration with health and social services (direct measures). To counter the creation of ghettos and segregation, social and cultural abandonment, to ensure quality and safety, it is necessary to develop specific projects that promote the formal and informal resources of the community, that give value to the residual resources of individuals, that develop social cohesion, neighborhood self-help capabilities, and street-level support (indirect measures).

To meet the need for employment inclusion, laws and regulations must be enacted that require public institutions and for-profit private entities to fully integrate individuals with psychosocial disabilities into the employment path. Supporting various forms of social entrepreneurship that promote employment and social inclusion is also necessary. Initiatives must be promoted to restructure the organization of work in a way that enables the actual employment of vulnerable individuals, and gives a return in quality and value for all.

To make these transformative and intersectoral policies concrete, it is essential that projects, including pilot projects, be initiated by innovative professionals, concrete bottom-up action based on comprehensive, continuous, shared care, oriented toward the recovery of individuals with psychosocial disabilities, not solely focused on medical, biological, and psychological responses but, together and even more so, on responses that address the social determinants of health.

Action that creates connections and alliances at the community level, that values the involvement of third parties, artists, students, intellectuals, professors, associations, cultural and productive groups, in other words, the civic resources of a community, capable of shaping new forms of relationship and exchange, forging new paths, and drawing new maps (Rotelli 2023) for mental health for everyone in the community.

Transformative practices are always collective actions that go beyond specialist boundaries and involve the resources of the entire community.

Only such practices can be seen as actions of collaboration with other services and political agencies called upon to respond to the non-health needs/rights of individuals with psychosocial disabilities.

In summary, for the transition from asylum psychiatry to community mental health that links with all policies, it is necessary to:

- Invest in strengthening the healthcare system as a whole

- End the asylum by definitively and surely blocking new admissions

- Promote the reorientation of human and economic resources from the asylum (which wastes the human resources of staff and patients, producing inertia and chronicity) to community-based generative institutions

- Invest in a mental health service system in the community based on human rights and commitment against all forms of institutionalization

- Implement intersectoral policies that leave no one behind

- Invest in the community, develop alliances and dialogue, promote participation and empowerment

- Intervene in power relations, in the way we understand and experience social relationships, in the fight against inequalities.

In conclusion, the Italian experience, the theoretical and practical work initiated by Franco Basaglia and continued by Franco Rotelli and the Trieste working group, enriched and strengthened by thousands of volunteers, students, interns, politicians, who came to Trieste from all over the world, has shown that it is possible to consider madness as a human condition present in each of us, like reason, and to affirm through concrete practices that a different way of assisting others (Basaglia 1979) is possible, that a society without asylums can exist, and that mental suffering should not exclude people from citizenship.

But much has been done, and much remains to be done.

In the dark times that many parts of the world are currently experiencing, it is important not to lose direction, not to retreat into inactive and defensive positions, not to lose optimism. We need to believe that hope and utopia are not the realm of the impossible but the realm of what is not yet possible (Basaglia), and to continue, even in small steps, on transformative paths and paths of social justice.

And together, build connections and networks among the good practices of community mental health scattered around the world as reference points, for comparison and support for everyone. We need this today more than ever.