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FROM FRANCO BASAGLIA TO COMMUNITY-BASED MENTAL HEALTH: TOWARDS A PARADIGM SHIFT

De Franco Basaglia à saúde mental comunitária: rumo a uma mudança de paradigma

De Franco Basaglia a la salud mental comunitaria: hacia un cambio de paradigma

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Abstract

This text analyzes the paradigm shift in mental health, criticizing traditional psychiatry for reproducing Western models of exclusion based on the asylum. Such models, anchored in the mind-body duality inherited from René Descartes, prove insufficient to deal with the contradictions between normality and deviance. From an epistemological and institutional critique, the emergence of community care as an alternative is discussed, emphasizing the centrality of subjectivity, social determinants, and citizenship. It is argued that deinstitutionalization implies not only the transformation of institutions but also the reconstruction of the relationships between knowledge, power, and care. It is concluded that the ongoing paradigmatic shift points towards a participatory epistemology and practices oriented towards social inclusion and the production of life.
Keywords: deinstitutionalization; community mental health; paradigm; citizenship; recovery

Resumo

Este texto relata e analisa a mudança de paradigma na saúde mental, criticando a psiquiatria tradicional por reproduzir modelos ocidentais de exclusão baseados no asilo. Tais modelos, ancorados na dualidade mente-corpo herdada de René Descartes, mostram-se insuficientes para lidar com as contradições entre normalidade e desvio. A partir da crítica epistemológica e institucional, discute-se a emergência do cuidado comunitário como alternativa, enfatizando a centralidade da subjetividade, dos determinantes sociais e da cidadania. Argumenta-se que a desinstitucionalização implica não apenas a transformação das instituições, mas a reconstrução das relações entre conhecimento, poder e cuidado. Conclui-se que a mudança paradigmática em curso aponta para uma epistemologia participativa e para práticas orientadas à inclusão social e à produção de vida.
Palavras-chave: desinstitucionalização; saúde mental comunitária; paradigma; cidadania; recuperação

Resumen

Este texto analiza el cambio de paradigma en salud mental, criticando la psiquiatría tradicional por reproducir modelos occidentales de exclusión basados en el manicomio. Dichos modelos, anclados en la dualidad mente-cuerpo heredada de René Descartes, resultan insuficientes para abordar las contradicciones entre normalidad y desviación. Desde una crítica epistemológica e institucional, se analiza el surgimiento de la atención comunitaria como alternativa, enfatizando la centralidad de la subjetividad, los determinantes sociales y la ciudadanía. Se argumenta que la desinstitucionalización implica no solo la transformación de las instituciones, sino también la reconstrucción de las relaciones entre conocimiento, poder y cuidado. Se concluye que el cambio de paradigma actual apunta hacia una epistemología participativa y prácticas orientadas a la inclusión social y la producción de vida.
Palabras clave: desinstitucionalización; salud mental comunitaria; paradigma; ciudadanía; recuperación

Introdução

Everywhere around the world a certain kind of psychiatry, which has simply imported Western models of asylum-based exclusion, is incapable of governing the social contradictions between normality and deviancy. That psychiatry betrays its origins in the history of medicine as an ideology: ie. the attempt to regain control of Nature embedded in the *mind-body duality*, and which finds its philosophical counterpart in Western thought from Descartes on. That is the trick of Western Thought that affects psychiatry.

The contradiction between a subject and an object is reflected in the position of the observer, the scientist, or the physician, entering into a relationship of knowledge vis-a-vis an object, which is the brain as part of the body, or the illness and ultimately Nature, which he must modify through treatment.

In this case, the contradiction of objectifying a subjectivity through an operation of exclusion, based on a nexus between power and knowledge, cannot be resolved. In his writings, Binswanger described the crisis of psychiatry as a science, ie. an epistemology or understanding that is conceived in relation to something that is real, objective and systematic.

> As soon as I transform my 'similar' into an object, as soon as I start to objectify him, in the subjectivity of his subjective being he is no longer my 'similar'; conversely, as soon as I subjectify the organism, that is I transform it from a natural object into a responsible subject, it is no longer an organism as understood by medical science. (Binswanger)

Phenomenological concepts like the juxtaposition "Korper / Leib" – the body as an object and the body as experienced by the subject - returned to this point. On the other hand, all the studies about the powerful effect of social determinants in mental health remind us of the complex relationship between the inner space of mind and social experience (psychogenesis and sociogensis). The concept of Self, as in Parsons, refers to social interaction and thus to the constructed or culture-bond intrinsic idea of a person, and Nature (biology) underlies the social experience.

The neo-positivist approach to psychiatry, in the form of biological models which seek to govern illness by acting upon the symptoms and/or otherwise confining the ill person in extremely restricted spatial-temporal limits, seems not to have fulfilled its promises.

Despite the massive use of new drugs, their multi-receptor profile, which makes them applicable to the most diverse conditions, instead of offering real advantages at the therapeutic level seem only to have created a greater tolerance (as shown by recent independent studies, e.g. CATIE and CUTLass1), while stigma remains linked overwhelmingly to the face of Psychiatry and to the reality of its methods and settings.

As Robert Castel foresaw in the '70's, modernization in psychiatry involves a downsizing and, at times, a partial superseding of psychiatric hospitals, at least in advanced countries, but rarely the closure of mental hospitals and never the interdiction of forms of coercion and exclusion, in a difficult balance between the ethical duty to 'treat' patients who are 'unaware' of their condition, and the mandate for the control of deviancy which society has always conferred upon psychiatry.

Once the social reality, or the community, is accepted as the new scenario, a different strategy imposes itself, based on the simple but radical observation that, by now, the greater part of the life-cycle of a person who suffers from a severe mental disorder takes place outside of the institutions that once defined that limit in an inflexible and often permanent manner, sanctioning an exclusion in terms which were truly absolute. This means creating alternative care practices which are, if not more effective, then socially and individually more acceptable than segregative and total institutions and which guarantee a true 'social reproduction' of the individual, even though (or even if) that person is ill.

Illness and institutions

There exists an entire stream of western thought which is critical of the application of the objective sciences to human beings and thus to the status of psychiatry as one of the natural sciences. Much of this criticism is based on a historical analysis of the roots of psychiatry itself (Husserl, Sartre, Foucault, Goffmann, Porter, Deleuze and Guattari). Because psychiatric knowledge has always been produced and modified through a dialectic process with the existing institutions, this knowledge became, at least in part, interwoven with the international movement for deinstitutionalization (M. Jones, Basaglia, Tosquelles, Laing and others).

According to Khun, we can say that a revolutionary break occurred with deinstitutionalization, which produced a rupture, and a radical change in both epistemological and practical terms. It modified the course and outcomes of mental disorders, and became "preventive" from the moment that it intervened in the institution itself, which had been identified as the focus of risk for chronicity, social exclusion, deprivation of power and the denial of the value of the experiences of persons suffering from such disorders. We can therefore posit a new model, or paradigm, that derives from deinstitutionalization at its heuristic-operational level.

This paradigm is based on the principle of complexity through the highly flexible interaction between observer and observed, that is, between "scientists" and "patients". It revolves around meaning and sense-making through new therapeutic actions conceived as "whole life projects" for people in need. In fact, we can define it as an "interactive comprehension model".

If we stop looking for an "in itself" of illness, and therefore for some absolute gnoseological claims which seek to apply an exhaustive knowledge to it, we arrive at the conclusion that illness is an "invented reality", which can be conceived as a series of concentric circles around the hard,

inner core of the "subject". Franco Basaglia, the Italian pioneer of deinstitutionalization, described this situation as follows:

> "Given the extremely reduced level of our knowledge in the area of mental illness (in particular schizophrenia, where we know the different ways in which it expresses itself, but virtually nothing regarding its aetiology), we cannot continue to "set aside" the ill individual while waiting for a more profound understanding of what exactly it is he or she suffers from, thereby increasing their suffering through internment and segregation. Instead, we should "set aside" the illness as an empty definition and simple act of labelling, and seek to create the possibility of life and communication so as to nurture and free up elements which can provide us with indications for future investigations. If the illness continues to be masked by institutional illness, it will be impossible to escape from this total identification which prevents us from obtaining any possible understanding." (Introduction and presentation of various work groups, 1974)

In short, Basaglia's question was not "what is mental illness?" (or, more philosophically, "madness"), but "what is psychiatry?".

> "If the psychiatrist wishes to understand and, especially, to have some effect upon the mentally ill person, he finds himself in the position of being forced to place the illness, the diagnosis and syndrome with which that person has been labeled between parentheses, given that the person is harmed much more by what the illness is presumed to be and the restrictive measures which have been imposed as the result of such an interpretation, than by the illness itself." (F. Basaglia, "What is psychiatry", 1967).

If Basaglia's most misunderstood affirmation (i.e. "putting illness between parentheses") is reread today in the light of a constructive epistemology, we see that it expresses a powerful need to remain within the "subject/object" relationship and to constantly question our actions and strategies, or "how should we deal with the patient's demands". Affirming, as Basaglia did, that the definition of illness expresses a "medical and social contradiction" meant, even then, that such a definition includes both the observer and the observed.

In the concept of "epoché", he would discuss the relationship with the illness, speaking of the implication of the observer's presence in the area being observed, but also with the overall context (framework, institutional conditioning, semiological horizon).

> "Psychiatry's current task might be that of refusing to seek a solution for mental illness as illness, and instead approach this specific kind of ill person as a problem which – only to the degree to which it is present in our reality – might

> represent one of the contradictory aspects which will require conceiving and inventing new forms of research and new therapeutic structures". (F. Basaglia, op. cit.)

Basaglia began with the problem of the body as organism and moved towards the "social" body, thereby placing into question the idea of a Norm, and of existing norms. Based upon this conceptual approach, he formulated his criticism of the objectification of the ill person in psychiatry and its institutions.

Basaglia's fundamental premise is that the psychiatric hospital is "institutionalised violence" (Basaglia). The institution expresses and reflects a given social structure and is functional to its mechanisms of exclusion (Basaglia), given that it reproduces a violent exclusion of the inmates. Here, Basaglia clearly refers to Foucault's analysis of madness: it does not appear, but is an epiphenomenon which is only "permitted" to emerge through the language of power, i.e. mental illness. In revealing the nexus between madness and deprivation/misery, it contains and reproduces that deprivation, like Foucault's history of madness reconstructed. Its all-pervasive presence infects the community like a 'social germ' (Maccacaro). It rationalizes madness as 'mental illness', in a place conceived around it (re Goffman). The institution creates a "double" of the illness, as a social role and overlapping behaviour. For Basaglia, deprived of a personal history, and thus without responsibility, the patient finds his new identity in the institution. The individual, without problematic or dialectic, becomes the symptom's strongest support, thereby reconfirming the medical model.

Institutionalisation is harmful not just because internment/seclusion prevents social reintegration and recovery and therefore favours chronicity (Ciompi), but because internment actually generates new forms of illness, such as the 'institutional neurosis' described by Russell Burton, or 'institutionalism' (Wing).

Basaglia's solution was to "cut across" the contradictions of the institution/psychiatric hospital, in the awareness that it was incapable of offering "emancipation". Ultimately, Basaglia came to the stark and radical conclusion, that the mental hospital had be phased out and finally shut down.

As an extension of his critical thought, he addressed the problem of Ideology, unmasking and interpreting not only "old" psychiatry, but new psy-techniques as hidden ideologies.

The restitution of meaning in the real world

Almost half century after Basaglia's death, we are still working towards a comprehensive restoration of the user's subjectivity, based on our firm conviction that this is always intelligible in his actions, even if those actions are conditioned by historical contingencies, among which the psycho-pathological suffering itself.

Various trends in the fields of philosophy, psychopathology, sociology, anthropology and epistemology regarding the issue of the restitution of meaning to social beings must therefore be evaluated. For instance, in the historical-anthropological approach to illness, meaning seems to constitute or structure itself through a series of nexi: with institutions, with prevailing traditions and with the contradictions of social life (Augè). The illness, seen as an elementary form of event, likewise leads us back to meaning, significance. Illness is a calling into question, a placing into discussion of the social by means of an individual life (illness as social signifier). The search for meaning thus appears as the search for ways in which the social reception of the fact and event takes place: as a message.

But we would once again be committing a fatal error if we did not link these trends to the reality of the psychiatric experience, which takes its departure from an anti-institutional practice and has as its primary aim the restoration of dignity and the conferring of a central role to persons hitherto considered only as semi- or partial persons to be clinically objectified.

Our aim is therefore not to discuss illness/meaning, or the semantics of symptoms, but rather the various montages and pathways of meaning by which the individual - as subject, as a subjective being - seeks self-affirmation.

Meaning is tied to an individual’s life history (and the links and nodes it establishes) and to power (recognition of rights, and the tangible access to and enjoyment of such rights). Just as subjective meaning (i.e. within the subject) and personal truth is always intelligible when the husk of illness is stripped away, so too is it present in the qualitatively different level of the observer’s interpretation. Meaning is thus deposited not only in experience, in actions, but also in their communicative value. The problem of “objective meaning” is identified with that of its social significance, in relation to prevailing norms; an event/experience to cancel or recuperate in terms of understanding - and thus a shared sense.

Deinstitutionalization does not only mean shutting down psychiatric hospitals, but also establishing procedures, or anti-procedures, which are critical of existing psychiatric practices and which will result in the gradual disappearance/ improvement /reduction of “illness” and the emergence of the “person” as a global entity. Specifically, these procedures involve the breaking of medical codes and the movement towards reciprocity; reconstructing the nexi “illness and…” (…and deprivation, and oppression, and the social/institutional environment, etc), which stands in opposition to illness conceived as a false autonomy; and rehabilitation understood as the restitution of rights (civil, social, legal); ultimately, human rights.

> “Diagnosis in psychiatry has, by now, assumed a categorical value, in the sense that it corresponds to a labeling beyond which no action or solution is possible. At the very moment the psychiatrist finds himself face to face with his counterpart (“the mentally ill person”) he knows he can rely on a quantity of technical knowledge with which – starting with symptoms – he will be able to reconstruct the phantasm of an illness; however, at the same time, he will

> have the distinct sensation that – as soon as he has formulated his diagnosis – the real person will have slipped from view because codified in a role which serves, above all, to sanction a new social status."
> (F. Basaglia in "What is psychiatry?")

But how has deinstitutionalization made personal suffering more visible, both within and beyond the context of illness? In the encounter with a community mental health service, there needs to be a free zone where it is possible to rediscover the rights of citizenship, and to manifest and express the contradictions and problematics inscribed within the individual. "Recognition" is not only "comprehension", but also discovering and "blazing" pathways of meaning. Included here are all those practices founded on reciprocity, and which aim towards empowerment and rehabilitation.

Deinstitutionalization and empowerment

In the new scenario of community care which has resulted from the closure of the mental hospital and the re-conversion of resources to community based services, there has been a shift from the relationship of domination/control to the therapeutic relationship, seen as a reciprocal relationship and not merely its objectification in the illness, and the rediscovery of the whole person and their subjectivity. From this point of view, deinstitutionalization can be seen as the change in relations of power: priority is given to the user's needs and actions, but in order for them to become "visible", the distance in the institutional relationship must be criticised and radically reduced.

In order to transform the actors of the institutional scene and the link between knowledge and power, Basaglia examined the pedagogy of power, that is, the ways in which all the actors involved, including the patient/user, can learn to use power for the transformation of existing conditions. Power is something that can be divided, delegated, or offered as a choice in a strategy of empowerment. Dismantling the psychiatric hospital's apparatuses of oppression and its hierarchy through a power-transfer was clearly a bottom-up / top-down process which aimed at this form of empowerment.

Re-evaluating life stories and situations before the patient's hospitalisation (or in any case before the encounter with psychiatry), restoring meaning to a personal crisis and re-evaluating possible resources in their social networks results in a holistic approach to the "person", to whom the sense of personal value and self-esteem and the integrity of their own needs must be restored. In order for the user's subjectivity to emerge, the operator must enter into play and engage with that subjectivity. The therapeutic/rehabilitative project that takes place within a new idea of the contract between the user and the "Service" (here meant quite literally) is one in which the user "takes and uses" what is offered in order to progress in existential terms. In this interaction, which

modifies both sides of the relationship, the elements of meaning are recognized together, within a mutual affectivity (or an alliance). But this can only happen within a context of restored rights.

The Service's negotiation with the user is a de facto recognition of the user's power and should take place during all phases and in all aspects of practice, from the contact (the question of consent) to the definition of the therapeutic program (its places, times and means). This does not mean that psychiatry renounces its responsibility and social mandate of control, but instead finds new ways of fulfilling that mandate. In fact, this responsibility must be *towards* and *with* the individual, not denying but enhancing and attributing value to the relation with a social context in all its complexity (social systems, social networks, institutions, community, society).

> "When the patient is interned, the doctor is free; when the inmate is free, it is the doctor who is interned! The doctor cannot accept this situation of equality: either one or the other must be locked up!"
> (F. Basaglia, Brazilian conferences, 1978)

In order to function, the therapeutic-rehabilitative program of an "open" Service should structure itself based on the user's indications, active will (or willingness), levels of health and social ability and with his aims and needs in mind. Rehabilitation means recognising that the user occupies a specific existential space and has a specific power, first and foremost with respect to the Service. The family needs to be increasingly involved in this setting as a pole of responsibility, and as an actor involved in decision-making, the question of resources, and as a critical limit for the therapeutic action.

The practice of a participatory decoding of crisis situations by these actors, a decoding which is constantly related to the facts of daily life, and to their causes, greatly reduces the aspects of manipulation, relational games and symptomatic behavior. These factors are instead interpreted as forms of communication related to a situation, and thus often deconstructed beginning with their institutional implications. Here it might be useful to recall Basaglia's view of "acting-out" as an act of rebellion against medical power.

From restoring the individual to community engagement

When we engage in a relationship with the individual outside the total institution and beyond that other "institution" that is the illness, our perspective widens to include the community, not only as a framework or a setting, but as a key player in the transformation process.

Over the past years, Basaglia's initial intuitions regarding the dismantling and reorientation of psychiatric power have developed in a two-fold way: towards the individual (and his subjectivity) as a social being, which implies a critical-theoretical approach to society and its norms, and towards the community. At the heart of this process was a shift from exclusion (guardianship) to a reaffirmation

of the social contract through empowerment and an increase in the individual's contractual power, thereby creating the material conditions for a possible re-entry into the real community.

Crossing the threshold from Inside to Outside was also, and primarily, the movement of single individuals (patients), of individual lives. In fact, it is through personal stories that one rediscovers ties with the community (the fisherman who was accompanied to his village near Trieste in order to find his relatives, and then returned repeatedly until he finally remained, restored to his original community). The integration of single individuals in the community sometimes resulted in the recognition of a form of belonging – thereby overcoming the fear of someone who was an "alien" twice-over. Sometimes the visibility and especially the free circulation of the ill person who was still clearly "different" or "strange", created scandal or led to the tracing of an invisible *cordon sanitaire* around that person. More frequently, it involved a difficult apprenticeship of adaptation, as in the case of normalised persons who were not permitted to have any social visibility in order to be accepted into anonymous condominiums.

Basaglia again:

> "When we began our reform process, in reality we violated society by forcing it to accept the "crazy" person, and this created major problems that did not exist before. The important thing, however, even as we violated society we were there (as new "technicians") to accept the consequences of this violence, and to take responsibility for our actions in order to help the community understand what the presence of a mentally ill person in society meant. (F. Basaglia, Conversations on Law 180, 1979).

The term "community" refers to the creation of a living space in order to enhance its potential for help, as opposed to the separation of a total institution. In the Italian experience of deinstitutionalisation, the term "community" (*territorio*) – as in "community-based psychiatry" and "community Service", instead referred much more to the actual local physical and social context and stressed certain key-elements such as: resources, access, networking with other services, human geographies and their policies. And thus the community as myth in many senses: a specific social place (social context vs. local context) which contains the promise of "health", which can "heal" (re-socialisation, social reintegration), but also a place which generates the contradictions that can lead to mental suffering, and thus, contradictions which it can either hide or reveal.

The therapeutic culture which the community develops within itself, and which forms an integral part of it, cannot avoid a relationship with the so-called "Norm", by "ignoring the culture of the outside world" and overly distancing itself from it. This problem reappears in the attempt, criticised by Basaglia, to reproduce Outside, in society, the model of Maxwell Jones' therapeutic community. In this instance, Society is seen "simply as a sum of interactions which can be understood and guided by means of psychological and psycho-dynamic techniques", thereby

ignoring the inevitable “questioning of the values and principles upon which the social group in which the illness manifests itself is based and, above all, the limits of the Norm - as that Group defines it” (F. Basaglia & F. Ongara Basaglia, 1970). The Norm should thus be understood not as a “given value” but as a “social product” (ibid).

The problem of the symmetry between micro- and macro- immediately arose. As we said earlier, the Psychiatric Hospital was considered the double of society, mirroring the social conditions and balance of power which sustained it. It was a photocopy of the social which was realised within it, as if dominated by a systemic rationality. And this, in turn, infected the community, sanctioning a specific ideology of illness and its treatment.

Even though the transformation process was made possible and sustained by local political-administrative decisions, the process involved clear violations of existing laws and social practices, which were based on exclusion. The alliance with persons oppressed by the institution was therefore an alliance “against the community”, in the sense that it refused to continue to contain the social misery that this community “dumped” into the psychiatric hospital, a “dumping” that was masked by the definition of illness.

The utopia of that misery being reversed and “poured back into” the community (the mass violation of the rules of internment as in the case of the famous horse, Marco Cavallo), and thus of its being rejoined to it by breaching the walls that separated it from that community, was a necessary element here.

In announcing the closure of the psychiatric hospital in Trieste (1977) Basaglia summarised this process as follows:

> “An important result for us is that the community Centres, by not exorcising the still precarious level of their practice, become increasingly meeting places for ex-inmates, new users and other people: figures which, if they do not have a common code of reference from the outset, progressively discover the terrain of their common alliance in the emergence of common needs and oppressions. Another important fact is that the so-called “patient management” seems to lose the totalising meaning which it had in the hospital: the total assumption of the person, the complete administration of his life. The end of “guardianship” and the beginning of the “contract” also signify the end of this type of management: it signifies the beginning of a discourse which is reciprocal and allows for opposition. Aside from the question of “management”, and in some place other than the asylum, our being with those who express distress, suffering and oppression, will now go forward in a relationship which is no longer that of guardian and ward, but the continuation of the struggle against the social organisation, and in favour of whatever consolidates and strengthens the level of power acquired by those who will no longer testify, who already refuse to testify in favour of torture.”

Working in the community

The creation of the Community Mental Health Centres, together with the process of moving beyond the Psychiatric Hospital, seems to have manifested all of the contradictions involved in moving towards the community. On the one hand, they remain small therapeutic communities "diffused and expanded", which aim at the maximum level of internal exchanges, the inclusion of family members, the involvement of ordinary people and volunteers and therefore the extension of the social support network thanks to a "community" quality in the relationships structured within it. They carry the challenge of the institutional dimension of relationships "outside", a quality which is, in itself, neither tolerant nor protective but based on a reciprocity among institutional actors/ entities made possible by a dimension of power which is no longer authoritative and legitimised by a form of knowledge.

On the other hand, the aim of the Centres is to develop the therapeutic dimension by functioning as meeting-places and locations for the democratic participation of ordinary people. Thus the "citizenship" assemblies in the Centres, when they first opened, in order to discuss their significance and possible uses. And then the constant search for the community, in its representational and organised forms (the collaboration with the community councils, as places for direct democracy), the first specific, focussed interventions, the offer of services and meeting places open to all, and the many critical stimuli aimed at marginal or alternative cultures.

While this movement was accomplishing its aims and the asylum disappeared, the "effects of the persistence of the asylum" (Rotelli) in the other healthcare structures, in the legal system and social services became strikingly evident, as if they had been unveiled by this process. The discovery of the "circuit" of the psychiatric demand was at the heart of the practices during this period, and was based on the "strong idea" of collective responsibility (of the service, the group providing care) for the ill person, of a therapeutic continuity – but not only – in real time and in the social reality of the community.

In dealing with the community, therefore, an attempt was made to "read" it strategically as a network of institutions (which, in fact, constituted the "circuit"). But it was precisely through the relationship-confrontation with the administrative that the process was transposed into institutional changes, in a specific, albeit empirical, engineering of the new services.

The territory as an "administrative" community was a codified space which had to be contaminated. In this sense, one spoke of the invasion of the community by the Services, or of going through the neighbourhood with the "long-term patient slung over one's shoulder". This movement from "Inside to Outside" was both necessary and consistent with the overall aims. The community possessed, in any case, its own form of truth and vitality, in its self-connotation as a place of power and relationships, as a space for socialising and thus of a possible reintegration.

For Basaglia, it was important to provoke conflicts, as many as possible, in order to activate subjects, persons around human suffering.

The Centres gradually stratified knowledge within the community, based on the interweaving of stories, relationships and conflicts. This "knowledge transfer" began as soon as the Centres presented themselves as points of reference and receptors for the demand, as places for the observation and transformation of individuals and groups.

Today, the Services are an integral part of the community, comparing and contaminating technical knowledge with the language and presence of real actors, both individual and collective, and restoring a possible sense of community through forms of social actions and communications within it.

> "The originality of the Trieste model perhaps consists precisely in this. Not so much, or not only, in its having tried to co-opt the city's population for its project (...) but rather in its having proposed a very direct terrain for confrontation, provided by the evidence of choices carried out in plain view of everyone. This resulted in the operators taking explicit and direct responsibility for every single decision taken along the way, regardless of their consequences, together with a profound identification of the operators with their patients. On the other hand, due to the conflicts that arose, this method offered the public possibility of indicating the contents and limits of a special form of action, with respect to the discrepancy that existed between the abstract adherence to the recognition of the patient's rights and the effective possibility of his having a degree of power in the life of the city. Verbal consent to the former can be easily obtained; but the second will inevitably create contradictions and conflicts which – once they have been faced and dealt with in real terms – can constitute the terrain for the growth of rights and the enrichment of resources for the entire community." (F. Basaglia, The therapeutic vocation, 1979)

Our experience of psychiatric practice based on the community as a tangible social reality is certainly characterised by a profound ambivalence. The real community has often appeared as an ideology or spectre: the plural community which is based on the person and not on individuals, which promotes and solicits mediators of community, has rarely manifested itself as such. For us, this is a difficult reminder that we are still dealing with a critical limit – ie. deviancy – and thus with the restoration to the community of a living portion of it, without which one "cannot provide" a true community.

Instead, a possible community can be glimpsed in forms of action which, as sociologists tell us, occurs via networks of help and support that appear after crises or negative events. Around the ill person and the Service will appear the community of conflicts and differences, still based on inclusion and, by reflection, on exclusion; a community which still requires judgements of diversity and still feels the need to clearly circumscribe deviancy. But where it will also be possible to find solidarity and the creation of a new awareness.

The Service must continue to question the community with respect to its definitions of normalcy, its mechanisms of exclusion and censorship (though it can do so only by placing itself, its ability or in-ability to produce health for the community – or simply its ability to "create community" – constantly into question).

At times, we have seen in the practice that "creating community" could exist, connected in some way to the social, inter-subjective meaning of events and new relationships among persons, and often transcending the new institution of "community" itself – the Service.

Today, the main priority is no longer that of maintaining the user's social context ("no to exclusion" and thus fighting the institutions that practice or enact such exclusion), but reducing social harm and **creating recovery processes, understood as the re-production of subjectivity in the social** (i.e. its networks and pathways), while never losing sight of the reality of the psychiatric disability which reduces the capacity for access and social opportunities.

Recovery as regaining power and finding meaning in personal suffering

If deinstitutionalization has made it possible to re-establish the rights of citizenship for persons affected with mental disorders by permitting them to regain a certain level of power but also by giving them a "voice" and the possibility of "expressing themselves", then it is important to understand the connections between alternative practices which are implicitly or explicitly critical of psychiatry and the new forms of self-determination, empowerment and the appearance of users-as-subjects on the social scene, as well as the connection between the possibility of integration and defending the value of the experience of suffering as a form of diversity.

The concept of recovery appears as an essential element for combining the experiences, which resulted from the deinstitutionalization of psychiatry and its institutions, with the knowledge that emerges from personal experiences through processes of empowerment and emancipation. Recent qualitative research sought to examine the recovery process from the perspective of the consumer. These researches, while confirming that the individual with a severe mental disorder appears as the main contributor to his own recovery process, at the same time underscores the crucial importance of social and 'institutional' factors with respect to this process.

We must move beyond the medical model which is based on the total delegation of the patient's body and mind to technicians. Recovery most definitely involves a *recognition* or awareness of oneself and one's problems, as well as the purpose or aims of one's existence. It has nothing to do with the "knowledge of illness" as a sort of "apprenticeship" for the institutionalisation of the ill person, who as a consequence of such institutionalisation is forced substitute his own body with the institution's body, ie. with an object, and incorporate acts and ideas which are not his own. It emphatically does not mean "recognizing illness" as a sort of 'training' or 'prepping' for the institutionalisation of the ill person.

Recovery should therefore be viewed as something beyond a merely personal process, for an excessive individualisation would imply a sort of "redemption" from a condition - the illness - which is still conceived as a fault or failing. Similarly, rehabilitation should not just be seen just as the reacquiring of skills, but also as a re-education, *but* in the language of power.

Another issue here is what individuals can do in order to change the dominant rules and ideas about health and illness. The first thing to do is break the automatic link between disability (illness) and stigma. For the person who suffers, recovery also means reversing the introjection of deviancy, thereby abandon the role of "being sick". In our view, the process by which a person becomes mentally ill can be deciphered, but not the illness itself, which is outside of discourse, and a form of existential exile.

A person can also become a therapeutic resource for his own recovery or the recovery of others, something which is now recognized by the figure of "recovery guides".

As Basaglia put it:

> "When we speak of a psychologist or a schizophrenic, a maniac or a psychiatrist it's all the same thing: there are so many roles within the asylum that we no longer know who is healthy and who is sick. I believe that a key characteristic of our work was that our unity was not technical but political: what united everyone were the political aims. Being a psychologist, a psychiatrist, an occupational therapist, etc. and being an inmate was the same thing because when we held our group discussions, everyone tried to make their own contribution for change. We recognised, for example, that a mad person was much more a therapist than a psychiatrist, and therefore the psychologist and psychiatrist were placed into question." (Brazilian conferences, 1978)

The recovery issue hence presents us with the question of how illness, as crisis, inscribes itself in the personal history of the individual: with what continuity or, conversely, through what ruptures, breaks and discontinuities.

As we said before, when 'the subject' appears, when the person becomes visible and illness/ psychiatry recede into the background, the possibility that suffering regains value as a personal process, as something with interpersonal significance for our social life and the possibility of coexistence also reemerges. The change implicit in recovery becomes possible when the person discovers a significant meaning attached to their crisis/illness, thereby enabling them to reevaluate their suffering. But this can only take place when there is a recognition by some significant other and/or a mental health service. The Service that is able to instigate such a process is a service that truly fosters, or even produces, "recovery processes".

In re-evaluating recovery as an interpersonal and social fact, we can distinguish three levels:

• Personal recovery, divided in turn into: complete recovery / social recovery / coping with symptoms;

• Family recovery: involving the family in a program to change persons other than just the "designated patient"; this means recognising that "his problem is also, in some way, my problem". This process often leads to significant social, participatory, community and political awareness (in the broadest possible sense);

• Community recovery: the recognition of the value of participation and the contribution which each member of the community or society can make to the ill person, or to someone with a history of illness, and not just in terms of solidarity but of integration.

Citizenship: the social dimension of recovery.

The search for and production of meaning and recovery processes are therefore the fundamental axes of psychiatric practice, while a return to normality and a unique process of emancipation remain the two poles for care and healing processes.

Where exclusion prevails, and the ideology of the asylum remains intact, the concept of freedom, and not of recovery, is paramount. Similarly, the concept of full citizenship has little meaning where freedom is lacking. Hence the need for a transnational and trans-cultural perspective of recovery, an approach which offers interesting research possibilities as to the substantially higher rate of recovery in Asian and African countries, despite the total lack of formal services.

If we prefer to speak of recovery *and* "emancipation", it is because we wish to emphasise the lack-of-freedom which is inevitably linked to the condition of illness as personal and social deprivation, the loss of rights, or the denial of access to socially exploitable resources; and, conversely, to the effort which must be made in order to "come back".

Most recently, this has been re-conceptualized as the "social capital issue", defined at either the community (Putnam) or the individual level (Bourdieu), as resources available in terms of relations and measured by participation, trust and reciprocity, which all work against social exclusion.

Here the lead value is not just solidarity, but providing common access to the "use-values" produced, something which Social Enterprise (as a comprehensive approach, and not just specific initiatives in the domain of social firms or coops) then developed more completely. In bringing together the intelligence of the real community or of another, invented or still to be invented community, Social Enterprise presents a cultural challenge with respect to the constant reiteration of the distance between the two worlds of production and welfare.

This causes a shift from the relationship Social/human needs to that between the State and the rights of citizenship, which in turn creates the possibility that those areas of inequality which psychiatry succeeds in intercepting and uncovering enter into a wider "channel", an area of

access to social enrichment. Today, the access to goods and services constitutes the parameters of social citizenship: and in this sense the "social value added" is nothing other than the creation of community.

Qualitative researches, based on patient interviews, which identify and register the factors involved and the personal meanings intrinsic to such experiences, seem to highlight the sense of community and participation that the experience of care/healing can open up. Such experiences offer the possibility of a new visibility which goes beyond both therapeutic omnipotence and the rhetoric of a passive adaptation or submission to systems of social regulation, for which psychiatry still functions as one of the "agents".

In the new international multi-center research on recovery, in which the participants include the USA, Norway, Sweden, Italy and Australia, two directions appear as most promising (albeit controversial): the importance of the "social issue" (participation, rights, power, inclusion) and the role of community mental health services in supporting personal changes by going beyond a merely "therapeutic role", and instead functioning as a sort of mediator, an *agency for integration*. Again, the concept of social capital reminds us that the Services possess or invest such capital only if they are able to promote trust, reciprocity and participation.

Although "recovery" processes often occur independently of professional help, we must continue to ask ourselves what the Services can do to facilitate the recovery and regaining of oneself, as opposed to institutional damage and the jatrogenic effects of treatments.

The deinstitutionalization experience in Trieste shows that turningpoints in recovery experiences often coincide with interventions by the Service, but that this is closely linked to the opportunities offered and the resources activated (e.g. working in coop, social activities, outings, mutual help, sports, joy, a social role, community experiences, sense of belonging, new identities, etc.). The Service makes the network emerge and become visible; the person realises that resources exist that can help them, or that they are part of a network (and thus "the social issue" again, on a micro-level). When operators move beyond the institutional relationship, true "decision-making" by users with regards to their own lives occurs, forcing operators to deal once again with the question of power.

A participatory epistemology?

According to the philosopher Juergen Habermas (*Ethics of discourse*, 1987):

> "If we compare the attitude of the Third Person assumed by those who simply tell us 'how things are' or how things function (the attitude of the scientist) with the performative attitude of someone who attempts to understand what is being said to them (the attitude of the interpreter), the methodological consequences for a hermeneutic dimension in research becomes clear.

> Firstly, interpreters enjoy the superiority of the observer's privileged position because, in virtual terms at least, they too are a party to the discussion on the meaning and intention of what is being expressed. Given that they participate in communicative actions, they accept in principle the same status as those they wish to understand".

We believe that a precarious definition of a "participatory" epistemology is linked to the deinstitutionalisation of the institutional relationship; to user involvement in services and empowerment; and to "a recovery vision" in the Service's practices aimed at emancipation.

> "Within a process of understanding – virtual or actual – there is no a priori decision as to who should learn from whom…Understanding 'what is being said' requires not only observation but participation.
> Reasons or arguments can be understood only to the degree to which they are taken seriously – and evaluated – as such, i.e. as arguments". (Habermas, 1987)

Instead of referring Madness to Reason, i.e. to given social norms, we must relate it to *reasons,* in the sense of finding and recognizing human reasons and explanations (Rotelli). We must grasp the radical nature of fundamental human acts and facts (estrangement - separation, nearness - distance) so that they can then be modified by practical actions. Once again the question is, what can we do for this person?

A Service is oriented towards recovery if it *is accessible* on a 24hr basis in the community and if it is *able to offer* something (affordable). An accessible Service is one where the user finds points and persons of reference and where he is received in a way which is human, warm and participatory; where there is a willingness to deal with the problems of his daily life and not just his disorders; where the institutional rules do not just impoverish, diminish, contain and compress the person in crisis. Basaglia once again: "In order to deal with the illness we must be able to deal with it outside of the institutions, and not only the psychiatric institution but any other body whose function is to label, codify and establish".

But he asks himself:

> "Is there an "outside" which it is possible to act upon before the institutions destroy us? The face of the illness as we know it is always "institutional": the norm reabsorbs into the institution every attempt to break it".
> And then: *"I have said that I do not know what madness is. It can be everything or nothing at all. It is a human condition. Madness is a part of us, just like reason is. The problem is that society, in order to call itself civilised, should except madness just as it accepts reason. Instead, our society recognises madness as part of reason, and reduces it to reason at the precise moment that there exists a science which is given the task of eliminating it. The asylum has its raison d'etre because it makes the irrational*

become rational. When someone is mad and enters an asylum, they cease to be mad in order to become sick: they become rational to the degree they are sick. The problem is how to loose this knot, how to overcome institutional madness and recognise madness where it begins, that is, in life itself." (Brazilian conferences, 1978)

Conclusions

Today, it may appear that everything gravitates around psychiatric power, since it has entered a network or a microphysics of other administrative or technical powers. But in fact it continues to provide them with "scientific" legitimacy. It is not a power based on force, but on knowledge, which substantiates and informs a new order and "establishment" in the healthcare and social domain.

Community care cannot merely provide an effective response to the "object-illness", but must focus on the person and expand the area of rights for people with mental health problems. The right to care must be linked to the rights of citizenship, the former cannot be given in exchange for the latter.

Change thus inevitably means closing down psychiatric hospitals and fighting against any form of seclusion and physical violation in mental health; and thus against all practices of dehumanisation and exclusion (psychiatric exclusion being a form of social exclusion).

The widely misunderstood Italian concept of deinstitutionalization, embodied in the Psychiatric Reform Act of 1978 (the 'Basaglia Law'), began with the de-construction of the institutions and psychiatry in order to arrive at the de-construction of the Illness itself.

In my view, *that kind of* deinstitutionalization implies emancipation, social inclusion and citizenship, which are words that must be linked to recovery in order to endow the process with more meaning and quality.

We must ask ourselves what conception of society and human beings underpins recovery. Otherwise, it merely remains within the medical model of illness (which doesn't interest me at all), as opposed to a "lay knowledge" which is seen as being intrinsically good, while at the same time being an ideology and reflecting the contradictions of social life. In my view, recovery can not be reduced to a personal technique for objectifying experience, nor is it dependent upon some 'shaman' or guru. On the contrary, I prefer to believe in the uniqueness of a person's recovery, in the same way I believe someone's personal truth when they are honest enough to acknowledge their limits and the contradictions inherent in any personal path.

As with self-help or empowerment, recovery still runs the risk of becoming a mere slogan or catchword, something used to create the illusion of change, and therefore and once again, an "ideology". Just as Basaglia refused any ideology, so too we must refuse the idea of a psychiatric service which remains locked in its own paradigms, whatever those paradigms may be.

I believe this to be a very real risk not only in Italy, but everywhere. Nobody explains how good, recovery-based guidelines have the potential of transforming services, which are institutions dominated in a very material way by their internal logic and their power structures. A good dose of "common sense"? Ethical choices? The only response is deinstitutionalization – perhaps in some new and different form, and based on the recognition of the user's contribution.

Participation, rights, power and social inclusion are interwoven with the role of community mental health services to support individual change, as agents for integration that can provide or be a catalyst for resources and opportunities.

Therefore, we can envisage two major implications of deinstitutionalization in a new epistemology for mental health:

• institutional change ('the observer') has been paired to a change in the phenomenology of the illness ('the observed object') toward a relativization into a given context of care and into a given culture of services;

• this is reflected by a split between illness (the object) and recovery (the subjective experience of the individual).

• A participatory epistemology, or better, an epistemology of change is necessary in order to compass this situation.

• Within this perspective, some of the basic elements for a new therapeutic practice today are:

• deregulation of illness (disassembly of the system within which the illness is oriented, steered) moving towards the relativization of its communications system, that is, the system of communication based on symptoms;

• strengthening self-direction and the sense of Self towards empowerment.

• inter-subjective practice among technicians and all actors: let's construct reality together in a community horizon.

Coming back to Kuhn's concept, there can no doubt that we are witnessing a period marked by a paradigm shift in the area of mental health. A paradigm (or a set of theoretical assumptions, practices and knowledge transfers) which is being challenged not only by increasing 'anomalies' of both an empirical and conceptual nature, but also by actual practices.

The paradigm shift currently taking place, even if in a confused way, is the passage from the biological-medical model for treating illness to the model of a response to real, tangible needs. These needs include the psychological and intensely subjective needs (or, as the sociologists say, post-materialist needs) of the person who is in a state of suffering, helping them in their often long and difficult journey of recovery and, if necessary, of emancipation. In a certain sense, therapeutic practice must get out of, or go beyond itself. In order to produce "health" it must first be able to produce "life". We must continue to demonstrate the useless and harmful nature of psychiatry, and relentlessly fight against the stereotyped, institutional image of illness. In order create a new

freedom in the field of healthcare, the medical model must be deconstructed and social integration and practices against exclusion must be promoted. Ultimately, health must be the result of both an individual and community project, and not just the result of institutions or social systems.

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