

From Institution to Community: theoretical and practical revisions of the concept of crisis in Trieste's Paradigm ²

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The transition from institution to community – from an asylum-type psychiatric approach to a community-based one that seeks answers to human distress in the space where it is expressed without seeking confinement – was accompanied by the search for new theoretical tools and the development of corresponding practices within socio-political frameworks that shaped and defined their character and philosophy. The concept of crisis in mental health is central, as the relevant theories provided an opportunity to renegotiate the content of mental illness and to reassess the psychological, social, cultural and political parameters that accompany it. At the same time, in an era where, despite the development of talk therapies, the medical-centric view prevails, a dialogue with the social sciences is opening up and traditional roles and methods are being questioned.

The concept of crisis presents significant difficulties in terms of its clear definition. As a term, it has been applied in various fields – such as economics, biology and political science – while in everyday speech it is used to describe the evaluation or formulation of an opinion. Sometimes, crisis is interpreted as criticism or evaluation, but it can also imply a sudden change. On the other hand,

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the need to treat the human being as a complex biopsychosocial whole and to examine the history of its suffering, without limiting ourselves to biological explanations, necessitates a holistic approach. This approach was sought in the middle of the last century, tested in practice, and contributed to broadening our understanding of the meaning of mental health, leading to a multi-level view.

This paper will examine the view of a crisis in Italy in the 1970s, through the ideology of deinstitutionalisation, with Franco Basaglia as its main proponent, who established a new philosophy of intervention based on moving beyond the psychiatric hospital and organising community services. This is a historical period that radically influenced the philosophy of interventions, interacting with social movements and challenging existing institutions and views, leading to new laws for the organisation of mental health services. This revolutionary process clearly showed that an alternative mental health culture – without coercion, restraint and paternalism – is possible and can yield significant results.

The contribution of the Trieste model has been recognised for its emphasis on human rights, social inclusion and patient autonomy (Schochow et al., 2024). Challenging the traditional biomedical model of psychiatry, has gained traction in many parts of the world, such as San Francisco (Portacolone, 2015). The Italian psychiatric reform, inspired by Basaglia's work, was a landmark event for European psychiatric care (Pycha, 2010).

Especially for the Greek context, the evaluation of the Italian example is considered essential, given that existing community services – as well as those intended to be created – are mainly limited to outpatient clinics, the issuance of certificates and other peripheral services that do not address the basic problem³. It is clear that the following data are also relevant to the Greek context, where the issue is not whether psychiatric reform has taken place, but whether the foundations for it have ever been laid.

The Historical and Social Context of Psychiatric Reform

In Trieste, a course was followed that aimed to move away from asylums, develop care and treatment within the community, and reduce admissions to psychiatric clinics of general hospitals. Theories that consider crisis as a part of human history, and interventions to it must be evaluated comparatively within the historical, social, and political context in which they developed.

³ A characteristic of the fragmented approach to the complexity of psychiatry in Greece is the fact that, at the time of writing this thesis, "Crisis Intervention Centres" were being planned, with the aim of using rapid and timely treatment methods to resolve the problem as quickly as possible, outside the psychiatric circuit. Their establishment was announced with the stated aim of reducing the number of admissions to psychiatric hospitals and was even provided for in the then new health law (3868/2010, Article 21). Reference to this failed, fragmented mental health policy will be made below.

In the 1960s, just after a world war that shook the entire planet, Europe experienced a powerful wave of questioning the institutions that had been dominant until then. The questioning of asylums was an integral part of this movement. In countries such as England, Italy, Germany and the USA, central issues arose that could be defined as the 'politicisation of madness'. This was a period in which, despite the development of talk therapies, mainstream psychiatry maintained a primarily biological and anti-psychological approach. As Vaia Kaltsi (2010) notes, madness and its subsequent definition as a mental illness were repositioned within social, political and historical contexts, which had become detached from an intense biologisation/medicalisation of the human being. Ronald D. Laing and David Cooper in England, and Franco Basaglia in Italy, opposed the "natural space" in which psychiatry and psychology had operated until then, questioning their mythical and stigmatising productions and provoking a re-examination of the concept of mental illness and diagnostic categories, rejecting the institutional establishment and psychiatric science as mechanisms of social control.

In 1961, Erving Goffman's work, "Asylums", was published, which became a point of reference for the detailed and thorough analysis of total institutions, tendencies of confinement, repressive procedures and mechanisms of exclusion, as well as the possibility of changing individuals through unlimited interventions based on rational choices aimed at educating, reforming, and treating subjects by subjecting them to the Asylum Rule. In the same year, in Europe – specifically in Italy – a project was launched to radically challenge the institutional system, with the aim of abolishing it. The basic realisation was that the psychiatric hospital had no therapeutic value, that there was a need to redefine the concept of treatment and care, and that the only way to give the psychiatric hospital a therapeutic dimension was through its transformation (Kaltsi, 2010).

As early as 1942, the first community-based experiments were introduced in England, where English pragmatism, free from the persistent theoretical thinking of continental countries under German influence, managed to break free from the rigid approach to mental illness. Main's experiences, and those of Maxwell Jones that followed, were the first steps towards a new institutional community psychiatry, based mainly on sociological assumptions (Basaglia, 2008-b). At the same time, a broad institutional psychiatric movement began in France, starting with Tosquelles, a nurse exiled during the Spanish Civil War who, after studying medicine, took over the management of a small psychiatric institution. From this small hospital, a new language and a different institutional dimension of psychiatry, was born, based on the psychoanalytic model, and the culture of the sector (organization settoriale) emerged.

The Italian experience borrowed heavily from the "sector" model of purely French origin and the "community" approach of English origin. As F. Basaglia

(2008-b) states, "we felt an urgent need for interventions that had to respond to the specific reality in which we were intervening, without being limited to predetermined, ready-made applications".

What we should take away from the Italian experience of psychiatric reform is that it manifested and expressed itself as a social movement, challenging institutions and relationships, and shaping the approach through revolutionary socio-political demands and beliefs. It was a process of transformation "from the bottom-up", both spatially and ideologically, linked to political and theoretical currents that challenged classical psychiatry, classifications and relationships of power and subordination, as well as the role of psychiatrists as administrators of power, and of treatment as discrimination based on specific criteria (Basaglia, 2008-b). Furthermore, therapeutic practice, which is directly linked to social movements, is highlighted as "an entirely revolutionary act".

It is clear that in Italy the concept of crisis is framed by socio-political characteristics and is part of an overall theory of mental distress and its treatment, in contrast to other examples, such as those in England, where emphasis is placed on specific concepts and practices without ignoring the psychosocial field. The Italian experience was based on the ideology of deinstitutionalisation and led to psychiatric reform (Law 180/78), which sought to radically reform the approach to mental illness.

Within this framework, the philosophy that developed also included the analysis and reshaping of the factors that cause the crisis. The individual interacts with the system to which he or she belongs, and therefore his or her crisis cannot be addressed in isolation. Like the individual, the system can also experience a crisis, making it necessary to treat both the individual and his or her environment. Furthermore, the crisis can serve as a tool for the service's emancipation, since the time and place of interventions are determined through negotiation between the service and the user.

The proposed practices do not differentiate between individuals in crisis with a diagnosed disorder and those without a diagnosis. Psychopathology is taken into account, but the symptom is interpreted as an indication that provides additional information about the individual's personal history and requires further investigation of each service's attitude towards them. It is clear that the 'Trieste school' considers it necessary for the service to take overall responsibility, integrating treatment and prevention as integral parts of the intervention.

Deinstitutionalisation as 'the utopia of reality'

The Italian experience, with Franco Basaglia as its main and initial proponent, was based on the ideology of deinstitutionalisation, i.e. the elimination of the consequences of psychiatric confinement and the violence it

entails (Giannichedda, 1988). The crisis is not necessarily approached as a negative event, but as a situation that can be interpreted positively in the development of a pathological process: in some cases, it is what sheds the "light" needed to understand a situation. The essential goal and means of this effort was the abolition of the psychiatric hospital and its replacement by outpatient structures, both spatially (within the community) and ideologically. The concept of crisis can be understood through the history of deinstitutionalisation, i.e. the history of the abolition of the "condition of social death" which, according to Basaglia (2008-a), is what the psychiatric hospital constitutes.

The analysis of the history of psychiatric institutions and asylums was one of the basic theoretical foundations for the formulation of the crisis approach and the development of corresponding practices in Italy, with the experience of Trieste being the most characteristic example. The "Italian experiment" began in the 1970s, at the same time that in other countries, such as Great Britain, the shift towards community psychiatry and the development of services aimed at avoiding inpatient care was becoming more established and widespread. Basaglia (1981), aware of these practices, describes, in his paper "The Utopia of Reality", the essence of these plans, which, in his view, determine the dominant trends in psychiatric modernisation in developed Western countries:

"...When one plans to organise a health service (in our case, psychiatric), the difficulty is to find specific answers to specific needs that arise from the reality in which one operates. But the answers that are relevant to reality should at the same time transcend it (through the utopian element), tending to transform it. In this sense, when designing a health organisation, one runs the risk of making two mistakes that are opposite to each other: on the one hand, that of proposing answers that go beyond the level of reality in which needs exist, creating new ones through the production of new 'ideological realities' that are tailored to the needs they are supposed to address. And on the other hand, that of remaining so attached to reality that they propose answers confined within the very logic that produces the problem they want to address. In both cases, reality remains unchanged and the answers are limited to defining and describing the problems of each particular sector...."

From the crisis of the institution to the new understanding of the crisis

The questioning of the institution of asylum was not limited to a one-sided renegotiation of the question of where the mentally ill should be treated. Instead,

it led to a broader redefinition of the concept of illness, a questioning of the neutrality of science and the role of the psychiatrist, and a breakdown of the distinction between "normal" and "abnormal" behaviour. According to Basaglia (2008), focusing on symptoms often means silencing a voice that, while expressing something specific, may conceal a deeper meaning.

From the late 1970s, when Basaglia developed his critique of crisis and, more generally, of the concept of illness, to the present day, the view of crisis has been shaped mainly by the "Trieste school" (Basaglia, 1980; Crepet et al., 1985; Mezzina & Vidoni, 1995; Dell'Aqua & Mezzina, 1988-a; Dell'Aqua & Mezzina, 1988-b; Norcio et al., 2001 etc.). This approach sees crisis as an evolutionary, dynamic, and flexible process that involves not only the individual but also the system surrounding them. According to this approach, we cannot separate the historical elements of an individual's life from their 'non-historical' moments, nor can we isolate the crisis in a separate space, disconnected from the totality of their experiences and relationships. A person in crisis is a historical subject, and their crisis cannot be examined as an isolated, unambiguous event. Rather, it is important not only for the present but also for the person's past. It is not always a negative situation; on the contrary, it can be a process that contributes to the understanding of a pathological process, shedding light on its causes and dynamics (Evaristo, 1988).

The approach to the crisis is crucial. It can serve as an opportunity for growth and maturity or, conversely, lead to regression (Basaglia, 2008-a). It does not concern exclusively the subject experiencing it, but also society and institutions, which are called upon to formulate responses that promote recovery, autonomy and emancipation. Only through this redefinition can the certainty of the "condition of social death" - which, according to Basaglia (2008-a), is represented by the psychiatric hospital - be avoided.

Mental health services can either integrate the crisis into the historical context of the individual's life and environment or isolate it, imprisoning it in a space cut off from the individual's life. The way in which the crisis is perceived and addressed – in relation to the individual's overall existence, context and history – greatly influences their journey through the psychiatric system. This approach determines whether their message will be accepted or rejected, and whether their existential contradictions will be perceived as real issues or simply reduced to clinical symptoms (Giavedoni & Rocco, 1988).

When crisis is approached exclusively through medical diagnosis, the scope of understanding the individual is limited. Instead of being treated as a suffering being, the individual is classified into a clinical category. As Mezzina (1988) points out, any definition of crisis must take into account the existing psychiatric system of a given region and period. An individual's crisis cannot be examined independently of the system in which they are integrated and with which

they interact. Given the context of mental health organisation, crisis takes on a specific meaning, influencing the subjective experience of the individual who experiences it.

Consequently, any approach to crisis must also include the crisis of the system itself that generates it and with which it is inextricably linked. Often, the psychiatric system focuses exclusively on the individual's "crisis", ignoring its own crisis. From a systemic perspective, the crisis of the mentally ill is intertwined with the crisis of the institution, which not only fails to deal with it effectively but often creates it.

The Italian approach to crisis, in the context of the deinstitutionalisation movement, constitutes an open conflict with the dichotomy of illness–sickness and normality–abnormality. Its development and treatment are linked to three main axes (Rotelli, 1983):

a) **The questioning of the 'culture of the psychiatric hospital'**, which accepts as natural the existence of spaces of confinement and coercion with all that this entails, from physical confinement and locked doors to the denial of needs and rights, through a military-style regulation of space, time and the needs of the mentally ill.

b) **The re-evaluation of the concept of mental illness**, which has been historically shaped by the psychiatric institution, based on administrative and legal frameworks in accordance with the conceptual parameters of prevailing normality and the practices of oppressive protection.

c) **Changing care** so that it does not reproduce the repressive structures of the asylum but is shaped as a process of rupture and transformation. Care is exercised as an act and as a relationship that breaks these codes and where, therefore, 'caring for mental pain' means addressing the 'illness of the institution' through a practical process of rupture and transformation of this form.

Since the early 1970s, deinstitutionalisation in Italy has progressed at different rates, and as a result, crisis intervention services have evolved accordingly. According to Rotelli (1992), this development depended on the extent to which eight basic principles, marking the new anti-institutional philosophy, were applied. These principles concern not only spatial relocation, i.e. the transfer of care from the asylum to the community, but also a more general change of orientation, which includes:

- **Transition from exclusion to harmonisation.**
- **Replacing abandonment with gradual reintegration.**
- **Redefining established roles and seeking new practices.**
- **Transition from cancellation to recognition of meaning.**
- **Shifting from diagnosing illness to exploring real needs.**
- **Replacing surveillance with empowerment.**

- **Shifting from the dominance of medical approaches to the use of human resources.**
- **Transition from restriction to freedom.**

These principles are a continuation of the views of F. Basaglia, who, as early as the late 1960s, argued that the concept of crisis in psychiatry is socially constructed and that its assessment should be based on a re-examination of mental illness through an investigation of the individual's experiences (Basaglia, 2008-b).

This reasoning means that understanding crisis cannot be limited to the application of a simple methodology. It does not seek uniformity, but rather to highlight the uniqueness of the problems experienced by each patient. This approach moves away from therapeutic interventions that are based exclusively on the medical model. Instead, it focuses on the individual's particular history, recognising the symptom not simply as a disorder, but as an important element that offers a deeper understanding of the individual's personal reality (Dell'Aqua & Mezzina, 1988-a; Dell'Aqua & Mezzina, 1988-b).

From institution to community: abolishing the psychiatric hospital

What is required, according to the above, is to delve into the individual history of the subject. Shifting the focus of psychiatric care to the community creates more opportunities for the service to come into contact with the individual (in the neighbourhood, in the workplace, etc.), which can be utilised to reconstruct their personal history. This allows us to understand the crisis through the relationships that shape it, without, however, always providing a complete explanation.

As long as the psychiatric institution remains static and inflexible, with the psychiatric hospital functioning as the last resort for 'difficult' cases, mental distress is treated as a problem that the service is called upon to manage, control and balance through specific intervention techniques. In this context, if the interventions fail, the psychiatric hospital is always the available solution for the "treatment" of the patient. According to this perception (Dell'Aqua & Mezzina, 1988-a; 1998-c), any therapeutic intervention ends up being short-term, as it is not based on extensive, continuous care for the person in crisis.

Consequently, practitioners are not prepared for possible failures, as there is always the possibility of resorting to more "serious" institutions, ultimately leading to the psychiatric hospital, and thus maintaining its centrality. Maintaining the psychiatric hospital as the final resort for people who refuse to accept the interventions proposed to them, guarantees the possibility of using more specialised and rigid techniques, so that the specificity of the problem is

finally recognised, behavior gets classified, separate and heterogeneous problems become homogenized, and thus, predetermined answers are given. The crisis is then 'read' in a predetermined way through convenient parameters.

In the case of Trieste (Dell'Aqua & Mezzina, 1988-b), the transition from psychiatric hospitals to the establishment of mental health centres – as the final phase of deinstitutionalisation – created a practical and theoretical problem. It is the problem of understanding the complexity that exists wherever there is a crisis. When the system fails to recognise the patient as a complex entity, it becomes simplistic and abstract. Then it is the patient's crisis that is addressed and not the crisis of the system that cannot manage the successive needs.

The critical methodological, epistemological and practical-therapeutic issue in a hospital-centred system is that the responses that can be given are limited to the reception of 'emergency cases' and thus always remain disconnected from the overall social and historical context that produces them. The "emergency" situation, in the form in which it usually presents itself, is the crisis of the mentally ill subject (i.e. the unmet and frustrated needs of the subject, their mental distress and anguish in their relationships with their micro- and macro-social context) must often reach extremely high levels of alarm, which necessitate resorting to compulsory hospitalisation, to be perceived and addressed. (Mezzina, 1988).

This is the moment when the person in crisis becomes the centre of attention, the moment that can be recognised as the moment of great simplification. The subject has already been progressively simplified, and the complexity of their distress has been reduced to symptoms, so that they are recognisable and visible. Psychiatric and hospital services, shaped within a medical-centric framework, are oriented towards the diagnosis and recording of symptoms, failing to take into account the multidimensional nature of the crisis (Dell'Aqua & Mezzina, 1988-a).

Crisis intervention: from theory to practice

According to the Trieste mental health services guide (World Health Organization, 2021; Mezzina, 2021), community services are managed by the Mental Health Department, which is responsible for the operation of the four Mental Health Centres (MHC), a smaller one within the university clinic, the Department of Diagnosis and Care at the general hospital (PDCS), and the Department of Rehabilitation and Accommodation. Each MHC serves a population of approximately 75,000 residents, is open 24 hours a day, and accepts requests from 08:00 to 20:00 through other mental health services, doctors, relatives, friends, and the persons concerned. It has 6 to 8 beds, and in December 2005 employed 249 staff, including 28 psychiatrists and 141 nurses. It provides a

day hospital, outpatient clinics, home visits (approximately 800 per month), psychotherapy sessions, family therapy, group activities, prevention, rehabilitation and support programmes, as well as counselling services. The literature and relevant references show that the two basic principles governing the operation of MHC in relation to crisis and intervention are "empowerment" and "taking full responsibility".

a) Intervention as an emancipating process

Mental health services must be able to understand the course that leads a 'silent' crisis, which has not yet been expressed, to the emergence of tense or even violent behaviour, as well as to the mental distress that ultimately triggers society's emergency mechanisms. At the same time, they must create conditions that will facilitate the individual's contact with the community, in places and contexts that are considered most appropriate for initial communication, depending on the particularities of each case.

According to Giavedoni and Rocco (1988), the way in which the first contact is formed plays a decisive role. The level of distress of the individual, the emotional response of the professional and, above all, the environment in which the meeting takes place influence the course of the intervention. For example, an interview in the place where the crisis occurred has a different impact than an interview in an outpatient clinic or psychiatric institution, where the heavy atmosphere of the environment can intensify the individual's anxiety and lead to more rigid behaviours. In this context, 'listening' takes on particular importance, as it reinforces the individual's sense of being heard, expressing their pain and being understood. Specialised knowledge and techniques need to be redefined and repositioned in relation to the subjects so that they do not function abstractly in relation to both the subject and the context in a direction that is intertwined with their transformation.

Mental health services, and especially MHCs, are structured on the basis of the perception that every crisis reflects an individual's attempt to manage the loss of their safety net. This is true even in cases where the crisis is expressed through violent behaviour, either towards others or towards oneself. The crisis, however, can be an opportunity for transformation, allowing for the recognition of the complexity of both the individual and the social context in which they live (Dell'Aqua & Mezzina, 1988-a).

Consequently, crisis can serve as an opportunity for emancipation, both for the subjects themselves, through the strengthening of their autonomy, and for their environment (family, work, social relationships), contributing to the reframing of events beyond stereotypical perceptions of danger or psychopathology. A meaningful understanding of a crisis requires the ability to shift perspective, from identifying with the person in crisis to understanding the dynamics of the environment in which they interact (Giavedoni & Rocco, 1988).

b) Taking full responsibility

A key orientation (Dell'Aqua & Mezzina 1988-a, 1998-c, Rotelli F. 1992, Mezzina R. 1997, Norcio B. et al 2001) is for the service to take full responsibility for the incident and not simply offer care. This means:

- i. Daily, round-the-clock operation**
- ii. Comprehensive (undivided) range of services.** A comprehensive service (CPS) provides a multitude of responses, avoiding the division of care provided by adapting the therapeutic process to cover the full range of multifaceted needs of the suffering individual in terms of prevention, care and rehabilitation.
- iii. Responsibility for a specific area.** Responsibility here does not mean that of classical medical ethics, expressed in 'medical-legal' terms, but rather the assumption of active responsibility for the mental health of the population of a given area, and functioning as an active point of reference for issues of conflict, unhappiness and disorder.
- iv. Active presence of the mental health centre.** The danger of social control as a legacy of the "old mental hospital" is guarded against by the creation of a service that meets the demand (ensuring access), so that the conditions are created for the request to be received in the most diverse, informal and direct ways possible, thereby ensuring the possibility of immediate and timely responses.
- v. No selection and no referral.** In other words, the MHC aims to become the main and only point of reference for the comprehensiveness of psychiatric requests in a given geographical area.
- vi. Continuity of the relationship in space.** The space where the relationship takes place is multiple. The therapeutic team acts inside and outside its own space, in a functional continuum. The subject in crisis, both during and after the crisis, is accompanied by the service, if necessary, throughout the network of socio-political institutions involved (courts, prisons, hospitals, schools, employment agencies, counselling services, etc.) with which the MHC is directly or indirectly connected.
- vii. Continuity of the relationship over time.** Working with patients who need long-term help is a slow, gradual process, with gradual progress, especially to the extent that it is not done on a "selection and referral" basis. Continuity over time can mean "waiting without expectations", i.e. that we accept, take on, brace, try to understand, allow the service system to co-evolve with the other person's system through interaction and "structural pairing".
- viii. Centrality of the subject in crisis.** This means recognising the negotiating power and rights of the sufferer, adapting the organisation of our work to their needs and problems, even in the midst of crisis. The MHC also acquires a symbolic character as a place of encounter and relationships, and not as a

place of restriction or exclusion. In any case, there are no forms of restriction (locked doors, isolation rooms, restraints).

ix. Community atmosphere and transparency of service. The flexibility of the service in crisis management and the way it takes responsibility does not imply an inability to deal with more complex situations. The MHC recognises the need to protect individuals whose behaviour (e.g. delinquent) carries a high risk of involvement with institutions such as prison, as well as individuals with reduced autonomy and severe dissociation, which can worsen their social relationships and exhaust the limits of social tolerance. In these cases, the centre takes full responsibility, often providing escorts for patients. However, intervention methods are tailored to the individual's needs and the professional accompanying them.

The timing of the intervention is particularly important and must be aligned with the individual's time in crisis. Respect for autonomy also requires respect for the individual's personal pace. The extensive study by Giuseppe Dell' Aqua and Roberto Mezzina (1988-a) emphasises this dimension. The time the person spends with the service must be meaningful, full of activities, meetings and group activities, both in a formal and more structured setting and in an informal, relaxed environment. The service must adapt its pace to the individual's needs, avoiding conflict and confrontation. The aim of the staff is to ensure that the daily life of the individual in crisis is not disrupted, but continues as normally as possible. The initiatives and suggestions of the person concerned play a decisive role in shaping the treatment plan and intervention, strengthening their position, promoting their autonomy and preventing the risk of objectification.

The therapeutic process is based on the relationship developed between the individual and the service, the creation of a therapeutic alliance and the practices applied. The MHC has ever-increasing resources at its disposal to respond to a variety of needs. These resources include the available support structures, as well as opportunities for meeting and socialising. The combination of these means with more medically oriented interventions forms a personalised therapeutic programme, tailored to the needs of each individual.

Community services and crisis intervention

All interventions aim to avoid hospitalisation, which is not determined solely on the basis of symptoms or risk factors, but also through a more comprehensive assessment that includes the supportive environment, the therapeutic relationship, the potential of the family or social context, and the available human resources (Norcio et al., 2001; Dell'Aqua & Mezzina, 1998-a; 1998-c). As mentioned above, hospitalisation does not mean separation from the environment, but rather, a search for ways to reconnect with it. Even if a patient

discontinues their hospital stay, efforts are made to reconnect and renegotiate in order to form a new relationship and a new therapeutic framework. Dell'Aqua and Mezzina (1998-a) point out: "Instead of following traditional crisis intervention strategies, which aim to resolve conflict within the family or micro-social context with the goal of rapid 'normalisation' of the subject, the response to the crisis tends more towards connecting the user with a wider network of social relationships and human and material resources available from the service".

The crisis plays a central role throughout the operational model, as it is **the starting point for change** and **the possibility of transformation** (Dell'Aqua & Mezzina, 1998-a; Norcio, 2001).

Specifically:

- i. **The crisis mobilises available resources**, seeking every possible social relationship that could support the therapeutic process and reactivate existing but dormant relationships. In this process, professionals encourage the person directly concerned to participate actively from the outset. At the same time, specialists rely **on reciprocity and directness** to build a bond of trust, even if they are met with denial or contempt.
- ii. **The crisis serves as a means of improving communication within the service.** The exchange of information, problem analysis, and sharing of knowledge and experiences during daily staff meetings help raise awareness among the entire therapeutic team so that they can collectively take responsibility for the intervention. At the same time, the flexibility of the service - which depends on the **continuous effort of collective work** and the contribution of each member of the team - is enhanced.

The multidisciplinary therapeutic team at the Mental Health Centre (MHC) is responsible for investigating the crisis, recognising the complexity of the problem and the multiple messages that arise from it. Usually, the team mediates between those involved and records the needs that emerge. According to Dell'Aqua & Mezzina (1988), an **effective response to needs** includes:

- **Strengthening the individual's ability** to take on multiple social roles.
- **Improving living conditions.**
- **Increasing the autonomy of users** and **reconnecting them with the social context.**

Intervention in a crisis, when based on the **specific needs** of the individual, requires the **cooperation of a multidisciplinary team** in order to:

- **Translate technical terms** into specific problems.
- **Avoid the tendency of psychiatry to ignore the material living conditions** of patients.
- **Promote interaction between different social factors.**

The services provided cover a wide range of needs, such as:

- ✓ *Living and accommodation*
- ✓ *Financial resources*
- ✓ *Personal hygiene*
- ✓ *Employment prospects*
- ✓ *Leisure activities*

Additionally, health professionals support service users in their daily lives by undertaking activities such as:

- Accompanying them to medical appointments and shopping.
- Assistance with paperwork and finding employment.
- Re-establishing connections with relatives and local networks.

All these functions contribute to the formation **of a meaningful connection with the outside world**, and promote a **more trusting and informal therapeutic relationship** between the user and the professional, outside the narrow confines of the MHC.

The patient's problems **are constantly redefined** through their relationship with the service. The user can gradually bring new needs, ignore previous ones, or move from the **incoherent speaking of crisis** to a **more organised understanding of their needs and expectations from life**.

In a study by Mezzina & Vidoni (1995) on people with severe psychiatric crises, **positive results** were found **with limited relapses** and **a good long-term prognosis**. Inpatient hospitalisations, both voluntary and involuntary, were significantly reduced thanks to the short-term accommodation of patients in the MHC.

Statistics (Tansella & Williams, 1987; Capparota, 1989; M.H.D. Training Programs Office, 2002) confirm the effectiveness of the intervention model in Trieste:

- **Compulsory hospitalisations** (at the MHC or the general hospital) amount to **7 per 100,000 inhabitants**, approximately **1/3 of the national average**, which has already decreased compared to the 1970s.
- **No increase in crime** related to mental illness **has been observed**, despite the absence of closed psychiatric wards and physical restraint measures.
- **There are no requests for permanent confinement** from the community.
- **The private psychiatric sector is non-existent**, unlike in the rest of Italy, where it covers 40% of services.

And all this in a city that once had 1,200 psychiatric beds for 240,000 people - now it has only six general hospital beds and 30 beds in a community overnight centre (Waters, 2020).

The transformation of services and the legislative framework

In Italy, the transformation of the psychiatric hospital was a turning point in the philosophy of mental health social services. It was primarily a **cultural transformation** rather than a simple reorganisation of services. Italy, as a country with great diversity and stark contrasts, found it difficult to adopt this transformation uniformly (Capparota, 1989).

Ramon (1985) points out that **Law 180/1978** differs radically from other European legislation, as it seeks not only to restructure the existing framework but also to **guarantee the employment of existing staff**. The services were organised in such a way as to **replace the psychiatric hospital** rather than complement it. In contrast, in many other countries, inpatient care – now mainly provided in general hospitals – is considered **complementary to community care** rather than an alternative to it.

However, countries such as **Great Britain** were influenced by the Italian example and especially by the experience of **Trieste**. In an effort to reduce admissions to psychiatric clinics, the UK established **Crisis Resolution/Home Treatment (CR/HT) units**. These units organise **crisis interventions**, home visits and escorts to community services, ensuring the continuity of care. The recommendations of **the National Institute for Mental Health (2001)** explicitly refer to the Italian model (Dell'Aqua, Asioli), which influenced them (Tansella & Williams, 1987).

Diversity in the application of Italian legislation

It is worth noting that Italian legislation focuses more **on organisational issues than on practical ones**. As a result, there is **considerable variation in its application** both between different regions and within the same city.

Jones (2001) compares the community services of **Sheffield** (Great Britain) and **Verona** (Italy), which have a common structure, as both have moved away from the psychiatric hospital. However, in Verona, the three sectoral services **differ significantly between them in their philosophy and practices**, while in Sheffield, despite their administrative separation between **the National Health Service (NHS)** and local government, they maintain greater homogeneity.

Jones attributes this difference to the fact that professionals in Verona have greater freedom **to interpret and apply Law 180**, unlike their colleagues in Sheffield, where stronger national and administrative systems limit deviations. Her research emphasises that, in order to effectively compare different psychiatric systems, **a study at the local level** is required, where the contradictions and peculiarities of each structure are more clearly highlighted.

Economic and political factors seem to play an important role in the formation and development of community services, as do geographical and

cultural factors, which Jones (2001) claims have not been explored at all.

According to a nationwide survey by **Gigantesco et al. (2007)**, there are **significant differences** between Italian regions in both the **structure** and **philosophy** of services.

The survey, which was conducted in:

- 23 university psychiatric clinics (average 17.3 beds),
- 16 mental health centres operating 24 hours a day (average 6.1 beds),
- 262 psychiatric clinics in general hospitals (average 13.1 beds),

concluded that **the most prevalent model** is a combination of **partially functional community services and psychiatric clinics**. As a result, community structures function more as **counselling stations**, while the **medicalised model of crisis intervention is gaining ground** (Norcio, 2007).

Legislation as a tool for innovation

Law 180 was **innovative** for its time, as it **broke with asylum-centred approaches**. Furthermore, it legitimised a **new approach to mental health**, strengthening the role of **interdisciplinary teams** in both diagnosis and crisis intervention.

With this law, the role of mental health professionals – beyond psychiatrists – was upgraded. These professionals took on **an active therapeutic role**, rather than being limited to **auxiliary or bureaucratic responsibilities**. The crisis **ceased to be considered an exclusively biological phenomenon** and began to be assessed as **a multifactorial process**, which **limited the primacy of psychiatric discourse** on it.

Contradictions and impasses of the reform

The nature of a community service is not determined solely by legislation. As B. Norcio (2007) and Th. Megaloikonomou (2003) mention - based on Dell'Aqua and Mezzina - the radical Italian psychiatric reform (**Law 180/78**) **highlighted** many of the contradictions and impasses of contemporary psychiatric systems. **The creation of psychiatric clinics in general hospitals** under the pretext of managing **emergencies** during the transition from the old system to the new, but also of compulsory hospitalisation, **highlighted the continuation of medical-centred approaches**. At the same time, **the underfunding of community services** led to **their functioning as outpatient clinics**, unable to provide **a real alternative to the hospital model**. Consequently, they were unable to provide **post-hospital care** and support to families, leaving significant gaps.

Intervening in the crisis *in Greece*

Terms such as crisis intervention and crisis theory are little known in Greece. Moreover, "psychiatric reform" is also a dead letter; much has been written about it, but it has essentially remained a constant proclamation, without any real implementation. In his book *The Psychiatric Reform and its Development: From Theory to Practice*, published way back in 1994, Madianos asks a question that remains relevant today: **"Were the foundations for psychiatric reform in Greece ever really laid?"** The Greek mental health model remains **underdeveloped and disconnected**, with outpatient services **fragmented, isolated from each other and often competitive**. As a result, the psychiatric hospital **remains the final resort** for individuals in **crisis**, who, once they exceed a critical threshold, are institutionalised.

Greece has one of the highest rates of involuntary hospitalisation in Europe, with more than **half of those hospitalised** being admitted against their will. The consequences of **incomplete psychiatric care** are evident:

- in the auxiliary beds in the psychiatric units of general hospitals, mainly in Attica,
- in the very high rate of compulsory hospitalisation, with 35-40% of admissions to psychiatric units in general hospitals in Attica, over 50% in psychiatric hospitals and lower rates in other regional units,
- the increase in beds in private mental healthcare facilities, particularly in Thessaly and Macedonia, as well as the full coverage of all those available in Attica.

The fragmentation of services also affects the level of care provided. The system is characterised by **separate lines of intervention**, leading to **fragmented responses to patients' needs**.

The Greek system applies the logic of **"one service for each problem"** (Megaloikonomou, 2003), creating new structures **without coordination between them**. Thus, features that we saw being implemented in Italy since the late 1970s are absent, such as a sector-based approach, with a single therapeutic team capable of organising differentiated responses to the multiplicity and diversity of requests, without the concept of referrals that burden the system and service users. In contrast, the Greek system **creates the crisis itself**, since the lack of coordination leads to **untimely intervention, a lack of consistency in the patient's therapeutic course, and the absence of organised secondary and tertiary prevention**, which could prevent social exclusion and the consolidation of mental illness (Megaloikonomou, 2003).

As Megaloikonomou (2003) states, the tragic lack of secondary and tertiary prevention (without this implying any underestimation of the importance of primary prevention activities) is one of the most critical elements of the shortcomings of our psychiatric system: it is precisely at these moments that a

strong and dense network of services that can deal with the crisis properly, prevents the symptoms and illness from becoming entrenched, and avert the patient's decline, exclusion, isolation, and personal and social devaluation.

A crisis, in essence, **is a moment of assessment and transformation**. However, the Greek psychiatric system **has never been fundamentally assessed** from within. All reform attempts have been, at best, fragmentary, and in their majority signaled a gradual return to chronicity, the maintenance of a psychiatry-centered approach, and a biologically determined perception. All reviews and reports (e.g. Giannakopoulos et al., 2016) speak of a psychiatric reform that was imposed as an obligation from 'outside' and 'above' and remains suspended within the limits of institutional logic and practices (Kaltsi, 2010). The existing model remains mainly hospital-centred and doctor-centred, with practices that view the crisis only as recurrent, and treat it within the psychiatric clinic, where balance is achieved mainly through interventions at the neurotransmitter level. There is a lack of daily practical support and assistance, of minimising disruption and maintaining social networks, of support from the early stages of the crisis, and of the active participation of the user and their family, elements that research has shown to be crucial in preventing hospitalisation, and which have been institutionalised in Great Britain (National Institute for Mental Health in England, 2001) or claimed and achieved in Italy.

A typical example of **the fragmented approach** are the **Crisis Intervention Centres**, which were established by **Law 2716/1999** concerning mental health. Their purpose was to **reduce admissions to psychiatric hospitals** and provide care **within the community**. **Law 3868/2010** provided for their further restructuring and strengthening. The law was developed as part of an effort to strengthen mental health services and deinstitutionalise the system, focusing on rapid and timely treatment methods to resolve the problem as quickly as possible, outside the psychiatric circuit. These interventions, which are short-term in nature and do not provide comprehensive care for the 'patient in crisis', lead to a disconnect between crisis management and subsequent care and rehabilitation. Without ensuring therapeutic continuity in time and space, the extent to which they are integrated into a comprehensive response to the patient's needs and, therefore, into a network of services capable of offering a comprehensive range of benefits and care that is an alternative to psychiatric hospitals (Megaloikonomou, 2003) is meaningless.

Many crisis and emergency situations and, consequently, hospitalisation could be avoided if people with mental illness and their families could benefit, for example, from:

- the operation of Day Centres, which would relieve the pressure on families and provide creative outlets for their mentally ill members,

- organised post-hospital care,
- therapeutic intervention in the place of residence,
- access to stable and suitable jobs, integration into social networks, securing decent housing and income, etc.

As international experience has shown (Carpenter, 2013; Duncan, 2021), to the extent that the aforementioned conditions are not met, "Crisis Centres" will not be able to deal with "bad outcomes" and will often be forced to resort to more "harsh institutions" - the psychiatric hospital - functioning as a supplement to it, instead of as a "filter".

In Greece, although it is widely reported, in practice, multidisciplinary therapeutic teams, where nurses take responsibility for the case as reference persons, have only operated to a limited extent. Instead, the model "go to the psychiatrist for medication, go to the psychologist for psychotherapy" is used. The role of each specialty is devalued in parallel with the fragmentation of the person in crisis, where their needs are not perceived as a whole and any treatment plan that is developed is completed with their discharge and referral to outpatient clinics. The **24-hour operation of community services** and the **assumption of areas of responsibility by the MHC** are **necessary first steps**.

However, above all else, what matters is recognising the central role of the person in crisis themselves. However, with mental health policies that promote profiteering and opportunism, and where alternative proposals are few and far between, this person wanders from service to service. In the author's opinion, the main element that the "Italian example" conveys is the need for constant review and reassessment, with continuous criticism of the system within which the crisis arises. In other words, if we consider that the reform has been completed, then we have already turned back.

References

- Basaglia F. (1980). *Crisis intervention, treatment and rehabilitation*. World Hospitals 16 (4): 26-27
- Basaglia F. (1981). L'utopia della realta, Scritti vol. 2: 1968-1980. Dall'apertura del manicomio alla nuova legge sull'Assistenza psichiatrica, Einaudi, Torino
- Basaglia F. (2008a). *Alternative psychiatry: Against the pessimism of logic, for the optimism of action*, Athens, Kastaniotis
- Basaglia F. (2008b). *Franco Basaglia: The institutions of violence and other texts*, Special edition of the "psychiatry notebooks", Athens, Bibliotechnia
- Capparota L. (1989). Italian psychiatric care - an update Journal of the Royal Society of Medicine Volume 82 August 198: 452-453
- Carpenter R. A., Falkenburg J., White T.P., Tracy DK. (2013) Crisis teams: systematic review of their effectiveness in practice. The Psychiatrist. 37(7):232-237. doi:10.1192/pb.bp.112.039933

- Crepet P., & Pirella A. (1985). The transformation of psychiatric care in Italy: Methodological premises, current status, and future prospects. *International Journal of Mental Health*, 14(1-2), 155-173.
- Dell' Aqua G. and Mezzina R. (1988a). Responding to Crisis: Strategies and Intentionality in Community Psychiatric Intervention in Per la Salute Mentale / For mental Health – Rivista del Centro Studi – WHO Collaborating Centre - Regione Friuli – Venezia Giulia). pp:139-158
- Dell'Acqua G and Mezzina R. (1988b). Approaching mental distress. *Psychiatry in transition: The British and Italian experiences* [e-book]. Boulder, CO US: Pluto Press;:60-71
- Dell'Acqua G. & Mezzina R. (1998c). *Integrated Care of People with Psychosis in the Community: the Approach in Trieste*
<http://www.triestesalutementale.it/english/archive.htm> (23/01/2011)
- Evaristo P. (1988) Urgency and hospitalisation. In: Righeti, A. (Ed.). *The psychiatric question*. Pordenone: Centre for Research in the Field of Mental Health, p. 225-232.
- Giannakopoulos G, Anagnostopoulos D. C. (2016). Psychiatric reform in Greece: an overview. *BJPsych Bulletin*. 40(6):326-328. doi:10.1192/pb.bp.116.053652
- Giannichedda M. (1988). Crisis and identity: Extracts from the theory of Franco Basaglia. In S. Ramon, M. Giannichedda, S. Ramon, M. Giannichedda (Eds.), *Psychiatry in transition: The British and Italian experiences* (pp. 252-260)
- Giavedoni A. & Rocco P. G. (1988). in Il Trattamento d'urgenza, included in the volume *"I dieci anni della 180*, Trieste-Pordenone,
- Gigantesco, A., Miglio, R., Santone, G., de Girolamo, G., Bracco, R., Morosini, P., Norcio, B., & Picardi, A. (2007). Process of Care in General Hospital Psychiatric Units: National Survey In Italy. *Australian and New Zealand Journal of Psychiatry*, 41, 509 - 518.
- Jones, J. (2001). The geography of mental health. *Epidemiologia e Psichiatria Sociale*, 10(4), 219-224
- Kingsford, R. & Webber, M. (2010). Social deprivation and the outcomes of crisis resolution and home treatment for people with mental health problems: A historical cohort study. *Health & Social Care in the Community*, 18(5), 456-464
- Lindemann, E. (1963). Grief. In A. Deutsch, H. Fishman, A. Deutsch, H. Fishman (Eds.), *The encyclopedia of mental health*, Vol II (pp. 703-706). New York, NY US: Franklin Watts.
- Madianos Michalis, (1994). *Psychiatric reform and its development: From theory to practice*, Athens, Ellinika grammata
- M.H.D. Training Programs Office (2002). *The organisation of the Mental Health Department Services in Trieste. Brief presentation*
<http://www.triestesalutementale.it/english/archive.htm> (accessed on 15/01/2011)
- Mezzina R. (1988). On the problem of crisis: codes and connections. In: Ten years of 180. Centre for Studies and Research on Mental Health in Friuli Venezia Giulia.
- Mezzina R. (1997, English version 2000). *The Trieste Mental Health Department: facilities, services and programmes*
<http://www.triestesalutementale.it/english/archive.htm> (accessed on 23/01/2011)

- file:///home/lykourgos/Downloads/The_Trieste_Mental_Health_Department.pdf
(accessed on 21/04/2025)
- Mezzina R. (2021). Trieste 50 years after: a more humane, person-centred whole system of care is now at risk in "Mental health, rights, equity, recovery and social inclusion in testing times" *WAPR Bulletin* N° 47: 23-31
- Mezzina, R. & Vidoni, D. (1995). Beyond the mental hospital: Crisis intervention and continuity of care in Trieste: A four year follow-up study in a community mental health centre. *International Journal of Social Psychiatry*, 41(1), 1-20.
- National Institute for Mental Health in England (2001). Crisis resolution and home treatment
- Norcio B. (2002). *Emergency and the Psychiatric Diagnosis and Care Service: The experience in Trieste* For a PPT presentation in London (GB), Senate House
<http://www.triestesalutementale.it/english/archive.htm> (accessed on 23/01/2011)
- Norcio B., Baldi C., Dell'Acqua G., Marsili M. (March 2001). *The Trieste mental health services: history, context, principles* - International Conference and workshops in Auckland, Hamilton and Wellington, New Zealand
<http://www.triestesalutementale.it/english/archive.htm> (accessed on 15/01/2011)
- Portacolone, E., Segal, S.P., Mezzina, R., Scheper-Hughes N., Okin R. L. (2015). A Tale of Two Cities: The Exploration of the Trieste Public Psychiatry Model in San Francisco. *Cult Med Psychiatry* 39, 680–697 . <https://doi.org/10.1007/s11013-015-9458-3>
- Pycha, R., Giupponi, G., Schwitzer, J., Duffy D., Conca A. (2011). Italian psychiatric reform 1978: milestones for Italy and Europe in 2010?. *Eur Arch Psychiatry Clin Neurosci* 261 (Suppl 2), 135 <https://doi.org/10.1007/s00406-011-0245-z>
- Ramon S. (1985). The Italian psychiatric reform. In *Mental Health Care in the European Community* (ed. S. P. Mangen), pp. 170-203. Croom Helm: London.
- Ramon, S. (1985). The Italian psychiatric reform. In *Mental Health Care in the European Community* (ed. S. P. Mangen), pp. 170-203. Croom Helm: London.
- Ratna, L. (1978). *The Practice of Psychiatric Crisis Intervention*. St Albans, Hertfordshire: Napsbury Hospital League of Friends. 101-115.
- Rotelli F. (1983). *Prevenire la prevenzione in "Devianza e Emarginazione", n. 12, December 1986, with Ota de Leonardis and Diana Mauri.*
- Rotelli F. (Trieste 1992). *Eight plus Eight Principles. For a Collective and Community Based Psychiatric Strategy (Towards Mental Health*
<http://www.triestesalutementale.it/english/archive.htm> (accessed on 15/01/2011)
- Schochow M., Ernst A., Steger F. (2024). *Franco Basaglia (1924–1980): the reformer of the Italian psychiatric system – Psychiatry in history. The British Journal of Psychiatry.* 225(4):468-468. doi:10.1192/bjp.2024.86
- Tansella M. & Williams P. (1987). The Italian experience and its implications *Psychological Medicine*, 17, 283-289
- World Health Organisation (2021). Guidance and technical packages on community mental health services: Promoting person-centred and rights-based approaches. 26 May 2021.
<https://www.who.int/publications/i/item/guidance-and-technical-packages-on-community-mental-healthservices>
- Κάλτση Β. (2010). Ανθρωπολογικές προσεγγίσεις της «ψυχικής ασθένειας»: Λόγοι ασθένειας, αφηγήσεις ζωής στα όρια του ασύλου (διπλωματική). Κοινωνική και πολιτισμική ανθρωπολογία, Πάντειο Πανεπιστήμιο, σελ: 9-16
- Μαδιανός Μ. (1994). *Η Ψυχιατρική μεταρρύθμιση και η ανάπτυξή της: Από τη θεωρία στην πράξη*, Αθήνα, Ελληνικά Γράμματα

Μεγαλοοικονόμου Θ. (2003). "Κρίση, Ίδρυμα, Κοινότητα - Η διαδρομή του ψυχικά πάσχοντα από τον εγκλεισμό στην εγκατάλειψη", Τετράδια Ψυχιατρικής, τ.83, σ.25-34