CLASSICS OF

Community Psychiatry

Fifty Years of Public Mental Health Outside the Hospital

Edited By

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Martha Lawless

Kenneth Thompson

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Scheper-Hughes, N., and Lovell, A. M. (1986). Breaking the circuit of social control: Lessons in public psychiatry from Italy and Franco Basaglia. *Social Science and Medicine, 23* (2), 159–178

Our readers may wonder why the longest article in a volume devoted to 50-plus years of community psychiatry in the United States concerns a mental health movement in Italy. The influence of this movement has, arguably, been limited mainly to ultraliberal and radical reformers in research, academic, and consumer circles in the United States. In addition, the article also goes into detail on the influence of German phenomenology, Marx, and the French Resistance on a psychiatrist-politician who produced little clinically informed work on community mental health care. Perhaps the best answer to these rhetorical questions is that the work of Franco Basaglia and his colleagues on mental health reform at disciplinary, institutional, and political levels in Italy during the 1960s and 1970s embodies a dramatic challenge to the U.S. approach to deinstitutionalization and community mental health. Or perhaps an even better answer is to pose another set of questions that suggest a way to pry open Scheper-Hughes and Lovell's rich account of mental health reform outside the United States: "What is 'democratic psychiatry' [the name of an organization Basaglia founded and a term that Scheper-Hughes and Lovell use in this article]? Does it make sense to combine a political term and the name of a medical discipline? Are they not separate domains?" Whatever the reader's answers to these questions, the historical, social, and political contexts of its setting must, in part, qualify the potential lessons that the Italian experience has for the United States. But only in part.

Breaking the Circuit of Social Control: Lessons in Public Psychiatry from Italy and Franco Basaglia

Abstract—Much public discourse in the United States and in Canada acknowledges the dismal failure of the policy to "deinstitutionalize" mental patients and to return them to some semblance of community living. The American Psychiatric Association has recently called for a reassessment of institutional alternatives—a call for a return to the asylum—in response to the needs of the new population of so-called homeless mentally ill. Here we contrast the failures of North American deinstitutionalization with the relative successes achieved in those regions of Italy where deinstitutionalization was grounded in a grassroots alternative psychiatry movement and professional and political coalition, *Psichiatria Democratica*. Democratic psychiatry challenged both the medical and the legal justifications for the segregative control of the "mentally ill": madness as disease, and the constant over-prediction of the dangerousness of the mental patient. In addition, the movement challenged traditional cultural stereotypes about the meanings of madness, and was successful in gaining broad-based community support from political parties, labor unions, student groups, and artist collectives that were enlisted in the task of reintegrating the ex-mental patient. The Italian experiment, although flawed and riddled with its own inconsistencies and contradictions, offers evidence that deinstitutionalization can work without recreating in the community setting the same exclusionary logic that was the foundation of the asylum system.

Key words—deinstitutionalization, community psychiatry, madness, social control

A plague upon you if you are deceiving us, and if among these madmen you are hiding enemies of the people [1].

With these harsh words the president of the Paris Commune rejected Philippe Pinel's proposal to free the 'lunatics' of Bicêtre asylum during the aftermath of the French Revolution. Central to the revolutionary fervor of 1789 was the attack upon the old penal institutions of violence and confinement that symbolized the tyranny of the *ancien regime*. Even the famed l'Hôpital Général in Paris came to be viewed as a less than benevolent institution, as a kind of prison for the containment and correction of sick paupers, a means of controlling dissent while, simultaneously, aiding the production of clinical knowledge [2]. Hence, during this period, legislation was proposed to extend home-based medical care and treatment to the sick-poor, freeing these unfortunates from their dread of public hospitalization. But the revolutionary spirit of the times came crashing down, finally, with respect to the treatment of the mad. Even the progressives

of the Paris Commune were not quite prepared to extend the revolutionary intent to madmen and lunatics, perceived as a class "who cause[d] horrible suffering to humanity" [3]. Instead, under the revolution, and later continuing under the Empire, the old institutions of punishment and confinement were gradually reopened and used for the internment of the mad, and for the mad alone, one social group totally abandoned by the revolutionary philanthropy of the times.

Consequently, the proposals of Pinel (1745–1826) in France and of Chiarugi (1759–1820) in Italy [4] that had originally attacked the very idea of institutional segregation of the insane, were recast as the more palatable proposals to reform and humanize those same institutions. This meant, in both instances, a movement to unchain mental patients within the walls of the institutions that continued to exclude and confine them. In place of torture and punishment a new regime of 'moralizing sadism' [3, p. 197] transformed the mental asylum into a new kind of court of law in which the madman was continually judged guilty of the crime of Unreason. The reforms of Pinel and Chiarugi, by leaving intact the whole psychiatric institutional apparatus, allowed the old contradictions between *madness* and *badness,* and between *custody* and *treatment* to be reproduced, and allowed the question of the humane treatment of mental patients to depend, precariously, on the temperament and treatment philosophy of the individual superintendent of each institution.

With the incipient psychiatric revolution of the late 18th and early 19th centuries aborted, for the next 150 years mental health reformers would continue to propose changes in the institutional treatment of lunatics, the insane, mental defectives, psychopaths, psychotics, the chronically mentally ill, etc. as each new generation of professionals would redefine them according to their treatment programs and agenda. Moral treatment, vocational rehabilitation, behavior modification, psychosurgery, therapeutic community, milieux therapy, institutional analysis, psychosocial treatment, etc. each represented a new gambit in the continuing search to legitimate the involuntary commitment of the psychologically different or distraught.

The more radical proposal to transform psychiatry outside the walls of the institution as part of a larger social movement to transform society as a whole waited to be taken up in Italy, once again on the forefront of psychiatric reform, in the early 1960s. The protagonist this time was Franco Basaglia, a brilliant, young Venetian psychiatrist who had assumed the directorship of an old, traditional asylum *(manicomio)* on the Italian-Yugoslav border. Basaglia, like many reformers before him, was revolted by what he observed as the traditional regime of institutional 'care': keys and locked doors only partially successful in muffling the screams and weeping of the patients, many of them lying naked and helpless in their own excreta. And he observed, with repugnance, the institutional response to human suffering: strait jackets, physical abuse, bed ties, ice packs, ECT and insulin-coma shock therapies to 'soothe' the terrified and the melancholy, and to strike terror in the difficult and the agitated.

A patient at Gorizia described the conditions there in the years before Basaglia arrived as follows, but he might have been describing almost any one of the provincial (public) hospitals in Italy at the time [5]:

> Those who were here prayed to be the next to die. Each time the bells tolled each one would say, "God, if only they tolled for me. I am so tired of this life in here". How many died who could have been alive and healthy! But humiliated and deprived of their humanity they refused to eat. Then the food would be forced down their nose with a tube. There was nothing else to do, locked up inside here with no hope of getting free. We were like scorched plants with leaves withered from drought.

The first time he entered the mental hospital, Basaglia later recalled, he was struck by a terrible odor—an odor redolent of death and defecation. It was not unlike the fetid odor of the prison cell where he had experienced his first institutional encounter when, as a medical student active in the Italian resistance, he was arrested and held prisoner under the German occupation. This formative experience provided Basaglia with the materials for his evocative equation of asylum, prison and concentration camp, as well as with a single-minded passion to *negate,* to destroy once and for all, the institution itself. Hence, his subsequent transformation and negation of the asylum at Gorizia shared intellectual roots, stemming from the Second World War, with the Saint Alban group in France that had provided health care for their companions in the French Resistance, while continuing to practice psychiatry. Under the leadership of Francois Tosquelles, a psychiatrist and a hero of the Spanish Civil War, the group went on to humanize the mental hospital by uniting insights from Marx and Freudian psychoanalysis. The Saint Alban experience culminated in a movement known as French Institutional Psychotherapy, which interpreted the dynamics of the mental hospital as the manifestations of a kind of collective unconscious, but which also took into account the social origins of psychological suffering. Institutional psychotherapy became the dominant alternative psychiatry in France, but it fell short in its ability to draw connections between the sources of oppression *inside* and *outside* the asylum, a task that Basaglia and his co-workers in Italy would accomplish later. Nor did institutional psychotherapy either challenge or change the fact of the mental hospital and its controlling functions. Nonetheless, several off-shoots and variants of institutional psychotherapy evolved, each with a distinct ideological commitment, among these Lourau's 'institutional analysis' and Mandel's 'socio-psychoanalysis'. Likewise, Franz Fanon, Felix Guattari and M. Mannoni had each, at some point in their careers, been affiliated with the institutional psychotherapy movement, and Basaglia often acknowledged the affinity of some of his proposals with ideas generated by these radicals and reformers of psychiatry. Franz Fanon, in particular, who like Basaglia, was a psychiatrist influenced by Sartre and existentialism, was one who also made the connections between oppression within the asylum and oppression outside [6]. Although disfavorable political circumstances forced Fanon out of favor before he could accomplish as much in the area of psychiatric reform as did Basaglia, Fanon's thought and evolving praxis went through many of the same stages.

Basaglia's intellectual roots also include an early commitment to German phenomenology. When Basaglia first assumed the directorship at Gorizia in 1961, he brought with him 13 years of experience as a research scientist at the neuropsychiatric clinic at the University of Padua. At that time existential phenomenology offered the only real alternative to the organicist schools that then dominated Italian psychiatry. Psychoanalysis, which also questioned the way in which biological psychiatry objectified the individual, did not really surface as a significant intellectual tradition in Italy until the 1970s. Basaglia then, became one of a score of younger Italian psychiatrists who embraced phenomenology, strongly influenced by the writings of Eugene Minowski, Ludwig Binswager and Erwin Strauss. The phenomenologist psychiatrists, reacting against the vast dehumanization wrought by the Second World War, sought to understand individuals through an appreciation of the diverse possibilities of their existence. This necessarily precluded enclosing individual patients within any system of fixed psychiatric categories.

Essential to Basaglia's analysis of psychiatric situations was Husserl's concept of 'bracketing': the suspension of judgements in the first encounter with the reality of the immediately given. It was Basaglia's 'bracketing' of mental illness as medical disease that provided ammunition to the critics who for many years falsely accused Basaglia of denying the existence of mental illness. Basaglia meant only to imply that we could not know what was the reality of the illness until we could first strip away the many layers created

by poverty, stigma, segregation, confinement that covered and concealed it. He made this point very clearly in an interview:

> It is not that we put illness aside, but rather that we believe in order to have a relationship with an individual it is necessary to establish it independent of the label by which the patient has been defined. I have a relationship with someone not because of the diagnosis he or she carries but for what he or she is. So, in the moment in which I say: this individual is a *schizophrenic* (with all that is implied, for social reasons, by this term) I behave toward her in a very unique way, knowing full well that schizophrenia, as we know it, is an illness for which nothing can be done. My relationship will be that of someone who expects only 'schizophrenicity' from the person. Now we can see how, on this basis, the old psychiatry had discarded, imprisoned, and excluded this ill person for whom it is believed there was no recourse, no tools for treatment. This is why it is so very necessary to draw closer to her, bracketing the illness, because the diagnostic label has taken on the weight of a moral judgement that passes for the reality of the illness itself [5, pp. 32–33].

In his day-to-day work at Gorizia, bracketing meant paying little attention to 'the diagnosis', and listening closely to what the patient had to say. Suspending the most general labels—psychotic, alcoholic, depressive- was difficult, for the trained clinician was then left without any other language. It was noted that often it was only the lay persons—the *'voluntari'* who later came to the hospital from the outside—who (innocent of psychiatric jargon and terminology) were able to break from the traditional and stagnating way of relating to patients. Basaglia's suspension of psychiatric knowledge also implied leaving behind the batteries of psychological tests, the mental status exam, diagnostic and statistical manuals in order that he and those who worked with him could see the patient in a new, evolving manner.

At Gorizia as elsewhere, Basaglia would always search to restore a subjectivity to patients, not only in individual therapy, not only in his writings, but through praxis—the collective effort to change, to verify the new ideas that emerged. But it was at Gorizia, too, that Basaglia came to realize the limitations of phenomenology, especially its inability to cast light on the class dimensions of psychiatric illness and the larger social and political forces that shaped its modes of expression. "Like psychoanalysis", Basaglia wrote in 1967,

> [Phenomenology] has yet to modify the nature of the relationship with the object of its inquiry. It keeps [the person who is ill] at a distance, in the same objective and a-dialectical dimension to which classical psychiatry has already relegated it. Both theories have penetrated institutional practices only very marginally [7].

Once he began turning away from phenomenology, Basaglia's emerging praxis was most influenced by the Italian Marxists who were developing a language to describe the changes and the emergence of a new social consciousness brought about by the 'Hot Autumn' of 1969 [8]. During this period the writings of Antonio Gramsci were rediscovered, and the concepts of hegemony, the role of the bourgeois intellectual and the development of critical consciousness were applied to the current context—in Basaglia's case, they were applied to a relentless criticism of the psychiatric institution, its logic and its professional and patient roles.

In this way Basaglia was able to confront, finally, the ultimate reality of the *manicomio* that would hereafter transform the nature of his psychiatric practice. This was the realization that the *manicomio* was not a hospital at all, but a prison:

> There are the doctors, white gowns, orderlies and nurses, just as in a general hospital, but in reality a psychiatric hospital is a custodial institution where medical ideology is an alibi for the legalization of violence [9].

At the heart of institutional psychiatry, then, was a lie, a gross deception: the institution existed not to answer the real physical, social and psychological needs of the patients, but rather to serve its own needs and those of the social order whose interests it represented. If the hospital was, in reality, a prison, and the hospital workers were prison guards, then reasoned Basaglia, there must have been a crime. But what crime had these unfortunate inmates committed? Unlike ordinary criminals, he concluded, psychiatric inmates were confined not for what they had *actually* done, but rather for the 'phantom' of what it was they *might* do, for what was presumed *could* happen. Institutional psychiatry was justified, in the final analysis, by the constant over-prediction of the dangerousness of the common mental patient, recruited from the marginalized, asocial and potentially unruly Italian underclass. This anxiety was clearly articulated in the existing mental health legislation (see below). In addition to the problem of potential dangerousness there were also the frequent violations of probity associated with the underclass—the public disgrace and scandals occasioned by the 'disorderly conduct' of the impoverished and working class 'mentally ill'. Here lies the core of Basaglia's class analysis of psychiatry. Basaglia recognized that psychiatric diagnoses were not independent of the prevailing moral and social order which tended to define normality and abnormality in its own class-based terms. There was, of course, the observation that the Italian public institutions—mental hospitals, orphanages, and reform schools—were crowded with the poorest and most marginalized classes of Italian society. Many of the inmates were aggressive adolescents and unemployed young men; many were women who deviated from the rigid gender norms of Italian society, the demands imposed by lower class marriage and family life. The presumed and intuited 'dangerousness' of these inmates could be linked to their ambivalent relations to societal norms, especially those related to conventional productivity and reproductivity. We could interpret their 'passive refusal' to participate in the commonsense but highly exploitative terms of productive and reproductive labor as a wildcat strike, thus explaining the need to remove them (forcibly if necessary), lest the strike spread to the rest of society.

Psychiatry, then, provided an ideology to cover over the layers of contradiction underlying the medical rationale for institutionalized violence against the classes of alienated poor found in the back wards of most public mental institutions. Basaglia concluded:

> Once the medical pretenses are gone, we can see the misery and the poverty that are the true nature of the asylum. The specificity of madness is also gone. The deception is obvious: it is one thing to say that an institution locks up fifty 'sick' people. It is quite another to say that fifty 'poor' people have been locked up because there is no other solution to their problems [10].

If institutional psychiatry was a lie and a whitewash for what was, in reality, a covert apparatus of brutal social control, then asylum psychiatrists were the original masters of deceit, or in Basaglian terms, 'special agents of public consensus', masquerading as men and women of science, and as caring and compassionate physicians. Institutional psychiatrists acted in the capacity of traditional bourgeois intellectuals, as defined by Gramsci, to swallow and ruminate any new type of thought, including even the most indigestible ideologies, in order to preserve the hegemony of the dominant social classes, whose interests they are paid to protect and to represent. Above all, it was the function of the psychiatric technicians to deny, to fail to see the reality of human needs expressed through psychiatric symptoms, especially the poverty and the exclusion of the mental patient both inside and outside the asylum. For Basaglia the psychiatric technicians diagnosed, with greater and greater precision and specificity, thus fragmenting the problem of 'mental illness' into a multitude of diseases so as to avoid confronting its *wholeness,* its unifying dimensions as a shared experience of alienated human needs.

Consequently, psychiatric knowledge is used, perversely, against the mental patient. Basaglia opens his essay, 'Institutions of Violence' with the evocative image of mental patients herded together into large day rooms where they are not able to leave, even to use the toilet [11]. If the patient soils herself, she is chastized for 'acting out' against the staff, or 'incontinence' (a symptom of regression) is written in on the patient's chart. The inhuman regulations of the institution produce signs and symptoms that justify locking up the inmate. Here deception is further confounded with self-deception, as one imagines the defenses necessary to maintain the legitimacy of this virulent and destructive social order. In the same piece Basaglia notes that hospital orderlies sometimes take advantage of the passivity and immobility of so-called catatonic schizophrenics by assigning two to a bed when the wards are overcrowded. The transformation of *patient* into *object* is almost literal, as in the note left by a ward nurse when she went off duty for the evening: "Before leaving all *locks* and *patients* were checked". In recounting this incident, anecdotal though it is, Basaglia captures the dehumanizing nature of asylum logic. Basaglia's critique goes far beyond what now pales by comparison as a limited and almost benign analysis of 'total institutions' (and of patients' methods of 'working the system') in Erwin Goffman's *ASYLUMS,* published in 1961, the year that Basaglia took over the institution at Gorizia. But how to proceed? What to do next? How to transform psychiatry as part of a larger program of transforming the society that produced both psychiatrists and mental patients?

The Theory and Practice of Democratic Psychiatry

The corpus of Basaglia's writings, collected in two volumes published after his death and running to more than a thousand pages [12], is of a theoretical, sometimes philosophical, often rhetorical nature, with only tantalizing and passing references to his own revolutionizing practice in the asylums of Gorizia, Parma and Trieste, and in the region of Rome. The history of his work and that of his followers in the Democratic Psychiatry Movement *(Psichiatria Democratica),* the powerful force behind Italy's radical deinstitutionalization movement and its sweeping and innovative mental health reform of 1978 (Law 180), must be reconstructed from the numerous Italian books and articles that capture the debates and controversies, and from newspaper clippings and journalistic writings [13].

As an individual Basaglia was charismatic, direct and uncondescending, explaining, in part, his enormous appeal to many segments of Italian society and his effectiveness even outside the country. Whether talking to factory workers outside Venice or to students at the University of Paris, or to psychiatrists in São Paulo, Brazil, Basaglia avoided the presentation of prescriptions, rules, models, or recipes for action. Rather, he offered a critical way of seeing, of spurning surface interpretations and easy solutions, and of experiencing the conditions of one's life. While he recognized that a sprawling city in a 'developing' country in Latin America was not analogous to Gorizia or Trieste, he empathized without restraint, and he stimulated and energized others, spurring them on to analyze their particular situation with their own cultural tools.

Mario Tommasini, the communist city councilman and health commissioner who eventually brought Basaglia to Parma, described some of these qualities in discussing his first meeting with the founder of democratic psychiatry:

> ... I found myself before a person who expressed a large, cultural openness, but who could relate this larger vision to everyday life, translating it into understandable behaviors and practical initiatives which—even if seemingly insignificant—were a stimulus to peoples' participation in social change [14].

But in his writings Basaglia left behind no famous case histories, no specific therapeutic techniques or practices. This was, of course, consistent with his epistemology of psychiatry as politics, with his rejection of the idea of scientific neutrality, with his suspiciousness of the traditional bourgeois intellectual. His brief, published 'excerpts' concerning the dramatic events and radical changes initiated at the asylum of Gorizia were

> not intended to be a description of a technique, or of a system that is more efficient or more positive than any other. The reality of today will differ from tomorrow's reality, and in trying to freeze it, it either becomes distorted or irrelevant [5].

Here Basaglia is taking up Sartre's conception of ideology that runs throughout his work: i.e. that ideologies can be liberating while they are still in formation and oppressive once they become institutionalized [15]. Instead of a technique or a system, then, Basaglia offers the dialectical method of negation, or negative thinking, a means of working through paradoxes to reveal the contradictions underlying traditional practice and logic. The 'negative worker' continually raises the questions: "What is *wrong* here?", "What is the *real* problem?", "Whose needs are being served—whose are being *neglected?'* Once the contradictions are exposed, and the group thrown into crisis, old roles and institutional arrangements and solutions are rejected, destroyed, negated, allowing new forms to appear. The work of negation could be devastating, for it entailed a refusal to allow the efficiency and well-functioning of the hospital to interfere with the unmasking of patients' real and unmet needs. In the case of Basaglia's anti-institutional movement the process of negation—pursued through open community meetings (the *assemblea,* to be explored below)—led to a denial of the custodial functions of the institution and a denial of professional roles and statuses in psychiatry, including a refusal of the power to name the illness, to define the norm, and to control through punishment or by over-medication. When you point out contradictions, wrote Basaglia,

> you are opening up a crack. For example, when we demonstrate that psychiatric institutions only exist as an apparatus of social control, the state is forced to create something else to replace it. From the time when the contradiction first explodes into consciousness, to the time when it is inevitably covered up, there is a moment, a chance for people to realize that the health system does not correspond to their needs because society itself is not organized to meet those needs [16].

It was in this tiny crevice, this fragile space that Basaglia and his co-workers tried to reconstruct psychiatry as a critical practice of freedom, a truly alternative psychiatry that would help resituate the marginal, the excluded, the scapegoated and help them reclaim their buried history. Through Basaglia's series of challenges to the false consciousness of individuals and of groups, and through the development of a collective practice, Basaglia, like Antonio Gramsci, merged theory and practice. He removed revolutionary praxis from the abstract domain of 'historical necessity' and returned it to the hands of real, active, critical human beings.

What made Basaglia's radical anti-institutional alternative possible was a confluence of factors obtaining in Italy in the early 1960s. The backwardness of Italian psychiatric institutions was anachronistic for a rapidly expanding capitalist society. There was as yet no bourgeois, liberal or humanist social psychiatry to compete with the prevailing bio-deterministic and other positivist models of mental illness, as existed for example in France, England and the United States and which spawned in those countries institutional psychotherapy, therapeutic community, the *politique du secteur,* and the community mental health movements. An attempt to import the French model of institutional psychotherapy by the Bologna Provincial Administration in 1964 had failed miserably.

Second, the existing mental health legislation in Italy was archaic, blatantly concerned with the control of social deviance and with anti-social behaviors (sociopathy). The mental health code of 1904 (with slight modifications in 1968) established the precedent of linking psychiatry to the Italian criminal justice system, and assigned it a function of control and custody *(custodia)* over that of care and treatment *(cura)*. The special relationship between psychiatry and the courts was, to an extent, overdetermined by the high proportion of young, "unsocialized aggressive", 'psychopathic' patients represented in the Italian mental hospital censuses. Italy's *manicomios* were filled with poor, working-class, and immigrant people, as well as with 'delinquents' and young social 'misfits'. In all they represented individuals who could not keep up with school, factories, or other institutions that reproduced 'normal' behavior.

Third, the sociopolitical context of Italy, with its strong labor movement and later, its student and feminist movements, offered the possibility of broad-based alliances and coalitions. Leftist trade unions and political parties were willing to give their support to the struggle against institutions that abused their constituents. University students and feminists were able to empathize with the most miserable and abandoned segment of the Italian underclass—mental patients—and to draw parallels between their situation and aspects of their own.

In 1961 when Basaglia began his work at Gorizia there were 800 patients in that asylum and nearly 100,000 in all of Italy. Despite the introduction and widespread use of neuroleptic drugs, psychiatric hospital censuses were continuing to rise. At the time of Basaglia's death in August of 1980, however, there were less than 50,000 mental patients in Italy and several traditional *manicomios* had all but closed down, and Italy had passed a revolutionary piece of legislation—mental health law No. 180, that effectively decriminalized madness, and which proposed to completely dismantle the old system of public asylums. As the principal architect behind these events, Basaglia's experiments at Gorizia, Parma and Trieste are instructive.

Stage One: Destroying the Mental Hospital (Gorizia)

As a first moment, Basaglia and his colleagues (including his wife, Franca Ongaro Basaglia) recognized the *manicomio* as a micro-social archetectural space that reproduced perversions in human relationships that were not only counter-therapeutic, but which created an illness specific to itself. British and American researchers had already recognized and named this phenomenon: institutional psychosis or hospitalism. The *manicomio,* wrote Basaglia during this period, was

> ... an enormous shell filled with bodies that cannot experience themselves and who sit there, waiting for someone to seize them and make them live as they see fit, that is, as schizophrenics, manic-depressives, hysterics, finally transformed into things [5].

And elsewhere he would state about the locus of his practice:

> Within its four walls, the pulse of history ceases to beat, the social identity of the individual contained therein is suppressed, and the process of total identification of the individual with its psychic dimensions takes place. The conditions of his life may be offered as proof of his innate inferiority, his culture disregarded as the expression of his irrational deviation. The silence which thus sets in, in the asylum, becomes both typical of it and the guarantee that from it no other message will reach the outside world [17].

The immediate milieux that he encountered was so inhumane that, like Philippe Pinel, Dorothea Dix and other psychiatric reformers before him, Basaglia sought first simply

to unshackle the patients, to end the more violent institutional practices of physical restraint, seclusion and shock treatments. He maintained chemotherapy as an intermediate measure, making it possible to eliminate the more immediately violent forms of treatment, and enabling him to begin to distinguish the damages produced by the illness from the damages produced by the institution. Chemotherapy, however, produced the first of many paradoxical situations that forced Basaglia to look for alternatives. Psychotropic drugs adversely affected the anxieties of both doctor and patient. They calmed the doctor's anxieties about his inability to relate to the patient as a human being, to find a shared language. On the other hand, the drugs increased the patient's level of awareness of his situation, convincing him that he was utterly lost and without appeal (why else would he be in a back ward?). Eventually, Basaglia came to the conclusion that medication could be used appropriately, and that there was a significant difference between using chemotherapy to suppress a 'symptom', and using it to establish a relationship. Medication could be used to put an anguished person to sleep, or they could be used to calm the patient down enough to talk with the doctor. But here another contradiction emerged. How to 'talk' with a patient who has lost all her subjectivity, whose only body is the body of the institution? In an early piece, while still heavily influenced by his phenomenological training, Basaglia challenged the clinician to search for meaning in the silences, in the stillness before the words, where the assaulted, battered psychiatric inmate could slowly regain her ego, recover her buried subjectivity, experience her sense of self, her ability to *be with* another, without fear of being annihilated [18]. Later on, the words might come more easily.

Similarly, the task of creating a more beautiful, more humane hospital environment also produced a contradiction. Basaglia recognized that the asylum could be transformed into a kind of 'gilded cage' where basic physical needs could be met (food, safety, shelter) but where more profoundly human needs (for autonomy, liberty, love) would be forever stifled. It was with respect to the failure of the 'open door' policy to radically alter the inmates' condition that allowed Basaglia to see the limitations of the therapeutic community model and which caused him to search for a more global solution that bridged the gap between *inside* and *outside* the asylum.

Where initially Basaglia considered the 'open door' the unifying symbol of psychiatric liberation, and he referred to it as the 'holy terror of our legislators', he soon discovered that the 'open door' merely reminded the patients of the fact of their exclusion and rejection by the world outside. Instead of taking the cue to freedom and autonomy offered by the open door, the newly 'liberated' inmates at Gorizia remained passive and imprisoned by an internalized image of the asylum that was part of their new sense of self. Basaglia would write with marked frustration:

> They sit quietly by and wait for someone to tell them what to do next, to decide for them, because they no longer know how to appeal to their own efforts, their own responsibility, their own freedom. As long as they accept liberty as a gift from the doctor they remain submissively dominated [9].

And so, the open door produced the third paradox: fewer escapes, less 'acting out', and the great quagmire of patient gratitude to the benevolent doctor/father. Basaglia drew on an ancient Chinese parable to explain the inmate's dilemma:

> An Asian fable tells of a serpent that crawled into the mouth of a sleeping man. It slid down his stomach and settled there, imposing its will on him and depriving him of his freedom. The man now lived at the mercy of the snake, and no longer had mastery over himself. One morning the man noticed that the snake had left, and he was once again a free man. But he no longer knew what to do with his freedom. During the long period of domination the man had

> become so accustomed to submitting his will to the serpent, and giving over all his impulses to the creature, that he had lost the capacity to desire, to strive, to act autonomously. Instead of his freedom, the man found only the emptiness of the void ... [5].

The analogy with the situation of his 'newly liberated' mental patients was startling to Basaglia, for they were still very much slaves of the institutional serpent.

Basaglia's immediate solution to prevent his newly emerging 'therapeutic community' from rapidly deteriorating into a 'cheerful haven for grateful slaves' was to engage his patients in a relationship of reciprocal tension, to challenge their mortified humanity, using as leverage each inmate's potential aggressivity. Basaglia encouraged even his most regressed patients to participate actively and aggressively in what he later referred to as the "destruction" of the hospital: first, to destroy, with their own hands, the more noxious barriers that had confined and excluded them: doors, bars, window gratings. An entire hospital wall was dismantled in a collective expression of what Basaglia later referred to as 'institutional rage'. On another occasion patients and nurses destroyed backward furnishings and equipment that were ugly, archaic, or symbolic of punishment.

The process of destroying the 'internalized' hospital—the negative logic of the institution—was more gradual, and took place through two main instances. The first was the task of opening up the wards by creating paid work in the hospital. To be able to work, and at Gorizia this could mean in the kitchen, maintaining the grounds, caning chairs or farming, gave patients a reason to leave the ward. It stirred the general stagnation and the emptiness of lives where all temporality and all contact with the external world had stopped.

By instituting fair standards of wage labor for employed inmates, Basaglia and his coworkers were able to expose the sham of previous models of so-called 'work therapy' through which unpaid labor was extracted from patients, a labor upon which the general maintenance of the psychiatric jail depended. As paid wages came to replace token cigarettes (the rewards for 'good behavior'), work in the hospital came more to resemble the social reality of labor on the outside, allowing inmates to feel more in common with ordinary working people.

By 1967 over half of Gorizia's patients were working, three times as many as when Basaglia had arrived. But this situation opened up new dilemmas such as whether equal compensation should be given to inmates of very differing competencies and commitment. Meanwhile, paid labor to inmates was introduced during a period of severe budget cuts. Lively discussions among patients and staff on these issues influenced the development of work cooperatives as a non-exploitative alternative.

The second instance of transformation was the meetings, and in particular the daily *assemblea,* a general gathering of patients and staff with a rotating chairman, elected from among the patients. This was a spontaneous event to which one could come and go, and no one was required to attend. No formal distinctions separated nurses, doctors and patients, and the topics for discussion came from the floor, centering on patients' needs, which they were beginning to express, both collectively, and as individuals. The *assemblea*are not to be confused with the general meetings that are part of the therapeutic community model of Maxwell Jones and his followers. Basaglia's *assembleas* were disorganized, uncontrolled, and open to anger, passion and unreason. They were anything *other* than 'safe' places for the 'controlled' venting of interpersonal or intra-psychic problems. A co-worker of Basaglia described the meetings as follows:

> The first *assembleas* were chaotic. They suffocated in a passionate struggle for power, the bitterness and hostility breaking through in both verbal and physical attacks. Certain administrators would scorn this event where everybody had a right to speak their mind, where the first

> stammering phrases of the most repressed and regressed patients were encouraged, where even delirious speech was accepted without stigmatization [19].

For some patients the *assembleas* represented the first public occasion at which their angry complaints were recognized for what they were—legitimate demands for unmet human needs—rather than suppressed as essentially meaningless symptoms of psychiatric disease. The recognition was both gradual and collective. For example, initially the meetings were disrupted by a patient who refused to enter the room, but who insisted on yelling through the window. What was first dismissed as the annoying interruptions of a disoriented patient, gradually came to be viewed differently by the group. The patient was not yelling through the window because he was crazy. Rather, the man was protesting. He, too, had found a way to use the *assemblea* to take power through speech, and his protest was henceforth recognized as a legitimate demonstration, an exercise of his civil rights.

What began to emerge at the *assembleas* was the collectivization of responsibility for the consequences of behavior. Individual problems were analyzed and translated into institutional terms. The dialectical method of negation, mentioned previously, is perhaps best exemplified in the way that problems were solved in the *assembleas*. One woman at Gorizia was using the *assemblea* as a vehicle to express her demand for electroshock treatments. Finally, the current president of the meeting—a patient—said: "Why do you feel guilty? Why do you want to be punished?" In the heated discussion that resulted, participants interpreted the woman's guilt in *institutional* rather than in *psychoanalytic* terms. That is, all the patients had, at one time or another, sought an explanation for their confinement. If they had been locked up, they *must* have committed a crime. Therefore, perhaps they *should* be punished. This perverse institutional logic, now finally brought out and uncovered for the sham that it was, provoked a crisis as the patients' long suppressed anger for their unjust commitment was allowed expression. The hospital as prison had to be negated.

There was a gradual evolution from the use of the *assemblea* as a place to vent personal problems toward using it as a vehicle for translating the personal into the collective and the political. If an alcoholic, for example, now free to leave the hospital grounds, went off on a drinking binge, his 'failure' was discussed as a shared responsibility. It became a crisis for the whole ward, not just for the individual, and a collective explanation was sought.

The new freedom to make choices, including the freedom to come and go on the wards, left open many possibilities for disruption and crisis that had previously been suppressed under the hospital-as-prison regime. For example, the *assemblea* might address what was to be done about a ruckus and free-for-all caused by an alcoholic who returned from town with a bottle of spirits in his jacket. The patient's action might provoke a collective decision to force another choice. Either the disruptive patient would have to leave the hospital, or he would have to act more decorously and responsibly.

Without a doubt, the most poignant expression of empowerment, collectivization of responsibility, and anti-institutional practice to have emerged at an *assemblea* took place in 1968, when Basaglia was indicted for manslaughter after a patient who was released into the community murdered his wife. According to a quirk of Italian law in effect at that time, the asylum director was responsible for the actions of patients committed to the mental hospital. There was an attempt to close down the asylum until a new director could be found, and the patients were to be transferred. Student and other community activists arrived and stayed at the hospital to keep it open. For 15 days there was no mention of 'the incident' at the *assemblea,* until finally, one patient exploded:

> Why can't we talk about this terrible thing? How can we keep silent when *he* [Basaglia] has to pay dearly for something we are all responsible for?

During the anguished discussion that followed, it emerged that everyone felt guilty for what the 'bad' patient had done. To both hospital workers and patients 'the incident' represented the frontline, symbolizing everything they had worked for. It was at the *assemblea* where most of the decisions regarding deinstitutionalization were made, including the timing of individual discharges, community and work placements, role of family members, etc. The decisions were not made by a panel of experts using psychiatric criteria. Rather, they were made collectively, largely on the basis of commonsense and lay criteria. If there had been a mistake in judgement, it should be acknowledged, but the responsibility for the error should be shared. It was a moment of crisis, but also a moment of breakthrough in the anti-institutional struggle. People wanted to stay together, to experience the trauma collectively, and so hospital and community workers started living in the hospital. As a result, for the first time real efforts were made to reach the most regressed, back ward patients, using play, gymnastics where possible, or any simple gesture that might come to mind.

The *assemblea* was one of about fifty meetings held each week by nurses, by other staff, and by smaller groups of patients. Visitors to the hospital were invited to attend and to participate. These meetings became instances of critical consciousness-raising through which 'new subjects' were created and collectively empowered. But the meetings represented only one of the collective movements that was to run through all Italian anti-institutional practice. Consciousness-raising and the creation and exchange of new knowledge also went on in the hospital cafe, in the spontaneous meetings with visiting family members and townspeople, as well as in more formal political forums. It is essential to understand how democratic psychiatry evolved as a practice.

While Basaglia's method of 'negative thinking' was used to confront contradictions and to pierce through the false consciousness of psychiatric and institutional ideologies, power-sharing was expressed symbolically as staff and patients gave up their traditional uniforms and with these their former role identities. And, with the 'open door' rendering it superfluous in any case, staff members relinquished their primary symbol of authority: the large ring of heavy, institutional keys. Yet, Basaglia and his co-workers never glossed over the fact that as long as the institution existed at all, nurses and doctors would continue to maintain control over the inmates, just as the doctors would control the nurses within a hierarchy that mimicked the division of labor in the larger society. Therefore, Basaglia and his equipe relentlessly examined the sources and the nature of their professional power, how it was delegated, and in the name of what objectives it was maintained.

The experiences at Gorizia went far beyond the techniques—such as therapeutic community—which had been borrowed. The meetings, as we have seen, bore no resemblance to group psychotherapy. Traditional therapeutic communities, as even the American sociological studies of the 1960s were revealing, never questioned the structure of power relations. At Gorizia authority, power and status were constantly rendered explicit, as problems to be challenged. Moreover, the contradictions within the hospital were linked to larger social ones. Basaglia and his co-workers gave priority to an analysis of the global and political economy dimensions of psychiatric problems in place of the more traditional micro-analysis of intrapsychic and interpersonal psychodynamics.

Finally, once doors were opened, new services appeared: a community mental health center for patient after-care; a school, a day hospital all on the grounds of the old institution. These were preparatory to the more difficult task of social reintegration that lay ahead.

In 1973 the various approaches and models would converge within a formal organization, *Psichiatria Democratica,* founded by Franco and Franca Basaglia and other members of the original Gorizia group. In their original founding document the group made the following pledges: (1) to continue the fight against exclusion by examining both its structural aspects in relations of production, and its ideological aspects in cultural norms and values; (2) to struggle against the asylum as the most obvious and violent paradigm of exclusion; (3) to avoid reproducing institutional mechanisms for exclusion in the community; and (4) to make a clear link between health and mental health care, especially through the reform of the Italian health care system.

It had been evident to Basaglia and his followers from the very outset that mental patients should not simply be returned to the same hostile families and antagonistic communities that had originally rejected them. He recognized that provisions had to be made for them: alternative social and medical services; adequate housing; and employment that was neither exploitative nor demanding. In short, the job of 'destroying' and, ultimately, closing down the wards of the *manicomio* had to be accompanied by the far more radical and difficult task of 'opening up' communities, making them more receptive and responsive, and more than just passively and indifferently 'tolerant' of the psychologically different, troubled, or suffering individuals who would be returned to their midst.

The work of Basaglia with Tommasini at Parma involved the first attempts both to go into the community, with the patients, and to work side by side with other organizations, such as unions, for broader structural changes. Basaglia did not entertain naive misconceptions about the readiness and willingness of Italian communities to accept the released 'madmen' and women. He recognized that his was a deeply cultural as well as political task, and that his co-workers had to confront and do battle with the demons of archaic superstitions and negative stereotypes about the 'mentally ill'. Italy did not differ from other Western countries in which 'mental illness' is a highly stigmatized condition, popularly viewed as incurable, even contagious, sometimes fatal and strongly hereditary. The stigma, therefore, attaches to family members of the patient, and is destructive to social relations in a society that is still, to a large extent, defined in terms of family ties. Basaglia was sympathetic to these families and their community relations:

> In our constant struggle against false consciousness and the dominant ideology, our work inevitably involves a certain violence to the community. When we release the mentally ill into the community in a real sense this is a violation of that community and it provokes a crisis [16].

First, there was the labor crisis: the problem of convincing unions and factory owners and managers of small firms to accept as workers a new class of social marginals who had either never worked before, or who had been institutionalized for so long that they had lost whatever work skills they once had. In this task Basaglia was greatly aided by the work of Mario Tommasini who, himself an ex-plumber, worked very effectively with the unions. His passionate humanism and commitment to the reintegration of ex-mental patients, especially troubled adolescents and the mentally retarded, was infectious. Once Basaglia had moved on to Trieste, Tommasini continued the anti-institutional work they had started together, particularly the work with labor unions and factory workers.

A deeply moving documentary film, produced in the late 1970s by the March 11th Film Collective and entitled 'Fit To Be United', captured the Parma experiment in process. In one segment of the film a group of metal workers discuss with some pride how they succeeded in integrating a dozen seriously mentally handicapped people into their factory, and how these people are now accepted as ordinary workers. A middle-aged man with Down's syndrome, flanked on either side by his co-workers, tells of his first, anxious day at the factory, and how he now tears out the pages of his calendar for Saturday and Sunday because

Stage Two: Community Praxis at Parma: "Everyone or No One"...

In 1970 the Provincial Administration of Parma invited Basaglia to take over the direction of its psychiatric hospital. By now the word about events at Gorizia had spread throughout Italy and elsewhere in Europe. The anti-institutional, anti-authoritarian nature of the Gorizian experiment resonated with the new values then being expressed in the student and worker protest movements of 1968. The currents of European marxism (in which both Sartre and the critical theorists of the Frankfort School participated) focused the struggle on groups and institutions that mediate between the individual and the means of production. Hence, the major unions, especially the GCIL, were turning to issues such as public schools and health care facilities, and they demanded a series of major reforms that would become central in the 1970s, as will be discussed at length further on.

Mario Tommasini, the provincial director of health for Parma, and other public officials had long been aware of the terrible conditions existing in the institutions of Parma and its surrounds, where neglected children, juvenile delinquents, unwanted elderly and mental patients were warehoused. In 1967, nurses had demonstrated against the 'instruments of torture' routinely used in the mental asylum by marching through the streets of Parma in strait-jackets, while the hospital itself (the former horse stables of Napolean's wife, Marie-Louise) was occupied in protest by medical students and the Parma Student Movement. Similar actions took place in other Italian cities: in Turin, for example, students demonstrated against the construction of a new psychiatric hospital. Meanwhile, the patients themselves went on strike in their sheltered workshops demanding higher wages and better work and living conditions. Many different popular and political organizations to respond to the problem of 'mental illness' and its treatments were spawned. Furthermore, political alliances were beginning to be formed between labor unions and the more progressive political parties. In the process of these linkages psychiatric issues were addressed as part of a general denunciation of segregation of all kinds and a new, critical examination of the social and political functions of medicine. Meanwhile, Basaglia was actively involved in attempts by workers to gain control of their health care and to change the many threats to health and safety at the workplace.

1970 also marked the diaspora of the original Gorizia group, for several years providing the only alternative to conventional institutional psychiatry. The publication of *The Institution Denied* in 1968, a collective product of the Gorizia equipe, made available the first synthesis and articulation of the anti-institutional practice (that Basaglia and his coworkers were developing) to a large public throughout Italy and abroad in Europe and Latin America. Members of the original group were invited to other cities and regions of Italy. Others, stymied by political barriers against the extension of the anti-institutional movement into the community of Gorizia, resigned in protest and sought to apply their practice elsewhere. In tracing the lines of dispersion outward from Gorizia, like the roots of a tree, we can begin to reconstruct the evolution of the movement. Of the original Gorizia equipe, Giovanni Jarvis went to Reggio Emilia where he by-passed the hospital entirely in order to set up community alternatives to hospitalization and to develop new forms of family therapy in public clinics. Agostino Pirella assumed directorship of the hospital at Arezzo which was to become a model deinstitutionalization experiment in Italy. Others came to Parma with Basaglia, and from there went on to Ferrara, Naples and Genoa. During this same period of growth and fission, an independent anti-institutional movement evolved in Perugia, which soon split along two fault lines: one developed a model for community psychiatry, with psychoanalytic overtones; the other developed a political practice which, nonetheless, emphasized *madness* rather than *marginality,* a departure from Basaglia's original approach.

these are his least favorite days, the days away from work and from his co-workers. This is followed by a candid, cinema verité sequence in which a militant union organizer apologizes to the camera and film crew for not being 'prepared', but he says that it seems to him that the way he and his workers have approached the problems of those called 'crazy' and 'retarded' is perhaps more useful than the methods and techniques of the psychiatrists. He adds that the relationships and the rewards are reciprocal, and that the presence of former psychiatric inmates on the factory floor—their pride and pleasure in work and in the company of others—deeply changed something at the factory: "Until their arrival we had lost a certain dimension, a certain way of being human".

The second crisis provoked by deinstitutionalization is to the families of the ex-patients, many of them ill-prepared to receive back into the bosom of the hearth family members who had proved troublesome in the past. This was especially so in the case of returning 'troubled adolescents' and so-called juvenile delinquents to their over-wrought parents who often lacked the skills and the resources to cope with behaviors that sometimes brought in the police. This dilemma was, again, captured in 'Fit To Be United' where a prematurely aged and worn mother of a young delinquent, Paolo (a boy filled with mischievous wit, charm and boundless energy), tried to explain why her son ran into so many problems with school authorities and with the law: "The problems were ours; we were poor, no? I've always had rotten luck". The return of her prodigal son from a mental institution closed by Tommasini was interpreted as just one more stroke of bad luck. One's sympathy is with the harried mother of eight other children, as well as with the difficult, but altogether winsome, Paolo.

Although Basaglia and his followers understood that the crises provoked by the return of the mental patient to be part of the necessary dialectic that made radical change possible, he also recognized the needs of the families for empathy and social and material support. "It is our duty", he wrote,

> *to work with those we have violated.* We must be present with them throughout their crisis [16].

Despite these words, in retrospect, a major shortcoming of Basaglia's work was his failure to develop any real praxis with respect to the special needs of those families to whom a deinstitutionalized member had been returned. Nonetheless, other co-workers in Democratic Psychiatry did develop new forms of family therapy and support in the community; Cancrini, for example, adapted aspects of Palazoli's 'paradoxical encounter' [20] (i.e. the Milan School) for work among families of the deinstitutionalized in Rome.

Central to Basaglia's community praxis was the work of a new species of mental health worker. The community presence that he envisioned implied a far more active and more political role for the worker than any that had previously been proposed. The work would require a clear rejection of the old psychiatric control apparatus. She could not serve simply as a go-between in revolving door relationships between the ex-patient and the mental hospital (so common among community psychiatrists in the United States) now that the institution no longer existed as a back-up social control apparatus. Without the threat of punishment and confinement lurking in the wings to extort conformity from the ex-patient, as crises arose they had to be dealt with on the spot. Nor were the new mental health workers to base themselves in community mental health centers and day hospitals which Basaglia always feared for their potential as 'involvement shields', barriers to community participation, and worse, for their potential of developing over time into micro-mental hospitals *in* the community. Rather, the new community health worker had to be fully present and available to the ex-patients in their daily conflicts in the real world, wherever these occurred: at home, on the job, at the marketplace, in bars and restaurants, at social welfare agencies, and in the streets and piazzas of the city. These represented new arenas

of struggle, for it was absolutely necessary that the former 'private' troubles of the patient be turned back into *public* issues, and that people's problems be understood as political and economic in nature, as well as psychological. The old 'false neutrality' and 'impartiality' of the 'objective' psychiatrist had to give way to situated and positioned community workers who were willing to take sides, and to put themselves squarely on the side of the ex-patients and their families.

Stage Three: 'Freedom is Therapeutic' The Hospital and the Piazza as Loci of Cultural Revolution (Trieste)

When he became director of the Psychiatric Hospital at Trieste in 1971, Basaglia was finally able to carry through to fruition the total elimination of the asylum, and venture forth fully into the unexplored terrain of the community. Trieste presented still a new situation: once part of the Austrian-Hungarian Empire, this magnificent city on the Adriatic Sea is home to a large number of marginal people, including many elderly and recent refugees from the Istrian Peninsula of Yugoslavia next door. Despite a 'white', or Christian Democrat administration, in addition to neo-fascist groups and political parties, the province's administrator, Michele Zangetti, was willing to promote the transformation of the mental hospital where 1200 patients were interned.

Trieste quickly became a crucible of innovations, experiments, actions. Young people, radicalized by the demonstrations of 1968, and the new political movements of the seventies, came to work as volunteers, or on student fellowships. Hence, non-professionals were a constant presence at the asylum, and the anti-institutional slogan, 'Freedom is Therapeutic', scrawled with other political graffiti on the hospital walls, captured the drama and the youth and the excitement of the early phase of deconstructing the hospital, as it were.

However, as the lessons learned through Gorizia and Parma indicated, one could not simply destroy the inner space of the hospital, leaving those once confined there at the mercy of the outside world. Alternative solutions had to be worked out, links re-established with the community; ex-patients had to develop new personal and social identities and to regain contractual power within the community.

The movement at Trieste, therefore, took place simultaneously on two fronts: in the hospital and in the community. Soon after his arrival, Basaglia restructured the hospital into 'open communities', corresponding to geographical sections of the province. But of primary concern was the reversal of the institutional logic that made the hospital a guardian and the patients its wards through the establishment of patient rights. Another step entailed reaching out to the community, enlisting the support of ordinary citizens, those for whom the *manicomio* represented 'protection' against the threat of chaos, disorder and dangerousness presumed to be contained within its walls. Popular stereotypes had to be confronted and challenged *before* and *throughout* the gradual process of returning inmates to the community.

In the asylum at Gorizia there had been the problem of that minority of inmates who were either too old or too senile, too physically frail or too deeply institutionalized, to return to community living. Three hundred of these still remained in the institution by 1968. Of these, approximately 100 were senile, infirm and bedridden, requiring constant care by the nursing staff. Another 100 were elderly and senile, but ambulatory, patients for whom the hospital was, for better or worse, their only home and they refused to leave. The final 100 inmates were chronically and actively psychotic individuals who were unable to function in the community or for whom no alternative placements could be found outside the hospital. And some of these, as well, preferred to remain living at the hospital.

At Trieste, on the contrary, even before most of the patients had left the hospital, a new legal status was created: that of *ospite,* or guest. Some of these could not yet find housing. Others, like some of the remaining patients at Gorizia, were either too elderly or too ill. But as *ospites* their full civil liberties were restored. They were free to come and go as they wished, with meals and lodging provided on the hospital grounds. Some worked even in the city. This was a *demedicalized* solution to the thorny problem of 'chronicity': neither medication nor psychotherapy was mandated.

But more than that, the creation of the legal status of *ospite* was part of a whole series of changes

> around the organization and disciplinary pillars of the therapeutic universe. Work therapy was replaced by the creation of a cooperative of workers; the ospites' lack of money set in motion a large machine to abolish interdiction and guardianship and to obtain pensions; the criteria for entitlements were modified through successive struggles and vindications; play therapy was ridiculed; art therapies were turned on their heads by experiments with animation, through which the city began to come into the asylum [21].

As the wards were unlocked and replaced with smaller units and by autonomous housing, such as the apartments where guests lived, the 'Basagliani' encouraged the flow of traffic through the doors to go both ways: inmates into the city, the citizens into the asylum. Staff went out to talk with families, officials and administrators. But for the latter to come inside the asylum, there had to be strong inducements, and these were provided in the form of film-festivals, and shows, plays by traveling repertory companies, performances by musicians, actors, artists. Naturally interspersed among the patients, townspeople could begin to recognize in the distress and suffering of former inmates some of the problems in living that plagued their own lives.

Basaglia and his co-workers had a particular affinity for the Italian artists' community, seeing in the works of the surrealists and post-impressionists, in cinema verité, street theatre, compatible metaphors of the sick-making contradictions of contemporary society. Through the vehicle of art there existed yet another way of sensitizing the public at large to the violence of segregative control. At Trieste, local and visiting artists were invited to participate in the anti-institutional movement, and some even moved into vacant wards and buildings. The best known group was the Rainbow Collective. With the inmates they painted colorful and outrageous murals, psycho-political graffiti, and ironic cartoons with captions such as: "Come and get your electroshocks with us; signed Pinochet". Sculptures created by Ugo Guarino and put on display in a former back ward gave mute but terrifying testimony to the suffering of the patients once imprisoned there. The collages were created out of the debris left from the stage of 'destroying' the hospital: bits of decaying wood, paint peelings, broken furniture stained with blood, sweat, urine and feces.

Outside the hospital grounds a group of actors and ex-inmates formed a company that performed puppet shows and guerrilla theatre on the streets and piazzas of the town. They enacted the history of the asylum and its inmates, and they celebrated the victory of its demise. In 1975 a group of artists worked with the inmates of Trieste in building a unifying symbol of the anti-institutional movement: *Marco Cavallo,* a giant, blue, paper-mache horse on wheels. Artists and ex-inmates paraded Marco through the streets and squares of the city, as a symbol—reminiscent of the Trojan Horse—of the freeing of the captive inmates.

Marco Cavallo, 'the large theatrical machine', the horse of the patients' desires, became a symbol, in schools, at fairs, in the marketplaces throughout Italy and elsewhere in Europe as well. But it brought out another, and darker side to the transformation of Trieste. The day of its triumphant exit into the city, the nurses went on strike, protesting the archaic conditions in which they worked, the long hours, impossible shifts, the paltry salaries. They

complained both of the present reality in which the mental patients lived, and of the poverty that awaited them outside. They were joined in the strike by all employees of the province.

The strike assumed a key significance for the anti-institutional movement at Trieste: it reminded movement workers that every extra lire for entitlements, every new room for a community center, had to be fought for. Basaglia was to reflect on the uses of power several years later:

> The problem of power and its pedagogy isn't about the empty attributions of power, but rather how it is conquered, and how we can change things through this conquest [5].

Eventually, Basaglia and his co-workers were able to open six alternative community mental health centers in Trieste, through their ability to build a power base of sometimes shifting alliances with the Provincial Administrator, political parties and labor unions. But when political constellations changed and became less supportive, or when funds dried up, the Trieste workers went directly to the townspeople, and began to collaborate with other institutions, such as the prison and the general hospital.

By the mid-seventies the foray into the community had produced a new phenomenon: poverty from the asylum now joined the poverty outside, that of chronic unemployment and housing shortages. There was also the poverty of human contact, that of loneliness, exclusion and abandonment. With no existing type of social services, a new response had to be created: a kind of arsenal of emergency assistance and welfare. By obtaining money for ex-inmates—and Basaglia and his staff continually badgered the provincial administration for higher entitlements—they broadened their possibilities and choices for community existence.

By the time Basaglia left Trieste to take over the psychiatric services in Rome in early 1980, the hospital was completely emptied. In Gorizia and other cities where Democratic Psychiatry had been active, the hospital walls and fences were literally torn down. In Trieste the buildings had been reconverted and reassimilated into the definition and parameters of community life. A beauty shop, dormitories for college students, the local pirate (alternative) radio station, and a cooperative day care center for children now occupied the emptied wards and buildings. The buildings, including those where the *ospites* still resided, were given municipal street numbers, symbolizing the rites of reincorporation. The effect of the blurring of the lines between 'inside' and 'outside' was described by one woman who worked at the child care center at Trieste:

> The significance of the presence of children in a mental hospital lies ... in the hope that one day we will stop building mental hospitals in and on the heads of children. The contradiction lies in the fact that "normal" children are in a space for "crazy" people. Hope lies in the possibility that this space could be used by the adult to learn to live with children [22].

Had Basaglia simply stopped with the destruction of the asylum, had he abandoned the physical space of the institution, he would have left intact the very *idea* of segregative control as a possibility to be rediscovered by other, newer agents of social consensus yet to come. Perhaps Basaglia was mindful of Michel Foucault's history of the total institution in Europe, with which we began this essay, by which each successive generation, each new episteme, recreated the old segregative and penal institutions to incarcerate, in turn, a new category of social outcasts. In this way, the leper was replaced by the witch and the heretic, who were in turn replaced by the debtors and paupers of the 18th century, and still later by prostitutes and defrocked priests, and finally all of these by the madman. In destroying the hospital as a locus of discipline and punishment, and by redefining and resocializing the shell that remained as a positive social space, Basaglia chipped steadily away at the cultural foundations of exclusionary logic. Instead of excluding the contradictions, isolating

and hiding them away, Basaglia's work returned them to our social space so that we might once again recognize that part of ourselves we have for so long denied as madness, as folly, as delirium. Having successfully challenged the special expertise of medicine and psychiatry in the management of human misery, Basaglia went on to confront the old and uneasy alliance between psychiatry and the law. Demedicalizing and decriminalizing madness went hand in glove.

Psychiatry and the Law: 'The 180'

The mental health reform bill, or Law 180, marks a final turning point in Basaglia's anti-institutional itinerary. It was an off-shoot of the anti-institutional movement's concern with breaking the circuit of social control that defined normal and abnormal behavior and which punished and excluded that which could not be domesticated or neutralized.

Law 180 begins from the premise that all psychiatric evaluation and treatment should be voluntary. It put a freeze on all new admissions to psychiatric asylums, and demanded that all current and 'chronic' patients be gradually discharged and reintegrated into community life through a network of new outpatient services. Meanwhile, all existing psychiatric hospitals were to be unlocked and patients' civil liberties returned to them. The law prohibited the construction of new psychiatric hospitals or the upgrading of all existing ones. 'New' patients were to be evaluated and treated in the community. If necessary, during an acute phase of illness or distress, a person could be admitted to psychiatric wards of general, district hospitals. These wards could not contain more than 15 beds, and in no case could compulsory hospitalization last for more than 15 days, with independent judicial reviews required at 2 and 7 days.

The significance of the law is apparent. Its unambiguous goal is the total abolition of the state mental hospital system. More important, the law recasts the relationship between law and psychiatry; 'dangerousness' is no longer the rationale for compulsory treatment and segregation. Nor is the law concerned with the definition and classification of the various types of 'mental diseases' (and the degree of threat each is presumed to pose to society). Rather, 'the 180' establishes the State's only interest in psychiatry as the supervision of the *forms* and *reasons* for treatment, both voluntary and compulsory. The law destigmatizes the psychiatric patient: mental illness is no longer treated as a special case of illness that allowed for special violations of the patient's civil rights. Instead, 'mental illness' becomes, under the law, one of many conditions (some infectious diseases are another example) which *might* require compulsory treatment or brief hospitalization. Gone in Law 180 are allusions to the 'irrationality', the 'mental incompetence', and the 'presumed dangerousness' of the mentally afflicted. Furthermore, the commitment process itself is politicized by assigning responsibility for compulsory commitment to the Mayor, an elected public official, in addition to two doctors. In other words, the delegation of responsibility to a 'gatekeeper' who is directly accountable to the public is made explicit. Commitment is no longer hidden behind a medical mask and confounding psychiatric language and false expertise.

Basaglia was the principal architect throughout the many phases of drafting the Law 180. In order to understand how he had reached such a level of political influence it is necessary to backtrack and explore the social conditions which aided passage of the legislation. In a fertile climate of change and experimentation—in the period between the student and worker revolts of 1968 and the end of the left-center coalition in the 1980s—Italians largely redefined the meaning of 'political'. Women, school children, parents, neighbors, workers, youth were the protagonists of the transformation, the 'new subjects' united by a common

denominator that ran throughout their demands and projects: subjectivity, personal needs, diversity, autonomy. The women's movement expressed this new current most clearly, perhaps, in their insistence of control over their reproductive system and the demedicalizing of pregnancy, birth and the female life-cycle. The labor movement claimed not only a right to occupational safety and health, but also control over health services so as to lessen their dependency on factory and company physicians. Similarly, Basaglia's incessant questioning of the parameters of normality and of reason resonated with women, youth and intellectuals. In this sense, health was central to the agendas of all these movements.

Health issues, including the questioning of psychiatric power, were taken up by the labor movement very early on. At a landmark congress on 'Psychology, Psychiatry, and Power Relationships' in 1969, health professionals, progressive intellectuals and representatives from the unions discussed concrete proposals, and the Italian Communist Party presented the first joint health-psychiatric care platform. Democratic psychiatry, too, had solidified its political base since it first brought together 2500 people at Gorizia in 1974. Although schisms rocked the organization (especially around the use of specific techniques), members united around the issue of much needed mental health reform. Gradually, local administrations had begun to develop programs outside the hospital except in the South where few such initiatives existed beyond Naples. Then in 1976, the heavy gains made by Left parties in the legislative elections boosted democratic psychiatry's influence, especially in the shaping of national health reform.

Basaglia, himself, became more politically focused following the *en masse* resignation of the Gorizia staff in 1972. Although he continued to work within his professional sphere as a clinician and psychiatrist, he also practiced beyond it, illustrated in his 6-year relationship with the Trieste administration, under Michele Zanetti, who translated Basaglia's concepts and ideas into political platforms and programs. In Western countries, the model of a psychiatrist who simultaneously operates on the local level, as director of a transformed psychiatric hospital, while actively negotiating the political system, from a global perspective, is altogether rare. Basaglia, also the archetypal *homme politique,* in his ability to maintain the double relationship to popular social movements and to established politics, was able to influence directly the sweeping mental health reforms of 1978.

During 1977, most of the political parties drafted and introduced proposals into the Italian Parliament for a national health service. The parties of the Parliamentary Left introduced legislation on psychiatric reform that incorporated many changes the anti-institutional movement had been advocating for several years: closure of the asylums, and of other total institutions (such as orphanages, special schools, etc); abolition of the 1904 law; establishment of community mental health as the core of psychiatric care; use of the general hospital for acute psychiatric uses; and overhaul of involuntary commitment and guarantee of a maximum of patient rights.

Shortly thereafter, members of the Radical Party, a champion of constitutional and civil rights in Italy, took to the piazzas with petitions calling for a referendum on a constitutional amendment that would totally abolish the commitment procedures and the public mental hospitals that were established by the 1904 law—but without any provisions for community-based alternatives. Due to general frustration with the pace with which the mental health reforms were taking shape in Parliament, they very nearly amassed the required number of signatures. It was largely out of fear that the Radical Party might succeed, and massive dumping of mental patients result, that Law 180 was quickly drafted and passed through the efforts of a Christian-Democrat and Communist Party coalition. Basaglia was consulted by the Law's sponsors throughout the period of its passage. The Radical Party initiative had separated psychiatric reform from the general health reform by limiting it to a constitutional amendment. To the contrary, the proposal that emerged as Law 180 was later

incorporated into the National Health Services Act (Law 833). The expediency with which Law 180 was drafted and passed had serious consequences to be explored below.

Although a compromise measure, the law reflected some basic tenets of Basaglia's work, especially the dismantling of the asylum system and the de-criminalization and depsychiatrization of 'mental illness'. The law, however, did maintain a form of involuntary commitment, and neither forensic hospitals nor private hospitals, nor university clinics fell under its jurisdiction.

In 1979, Basaglia moved to Rome to become Director of Mental Health Services for the Lazio region. Before his untimely death in August 1980, he was able to witness the rather striking immediate impact of 'the 180': the large decrease in public hospital patient censuses (from 54,000 in 1978 to 42,000) and the 60% decrease in compulsory admissions. In addition, National Research Center Statistics had indicated no corresponding increase in admissions to private facilities or evidence of dumping. Definitive studies and evaluations of the effects of the law are yet to come, and up-to-date reliable statistics have not been published. After an initial wave of enthusiasm, however, its supporters became aware of the problems involved in implementation, including direct sabotage.

Opposition to the so-called 'Basaglia method', which its detractors eventually identified with the 'Basaglia law', came from various sources. Already in the seventies, Basaglia's work had been contested in lawsuits and other types of harassment. Meanwhile, traditional, biodeterministic psychiatrists had been gaining strength with a resurgence and reformulation of positivist psychiatric models beginning in the late seventies, while classical psychotherapies were enjoying their first broad support. Hospital nursing staff had gone on strike against 'open door' policies, on the grounds that *they* would have to take the brunt of patient aggressivity 'unleashed', once inmates were free to move about. And although no jobs were lost when wards or buildings of the mental hospitals closed down, many hospital staff rejected the alternative of working in the community. Like chronic patients, these psychiatric workers were often 'over-institutionalized'. And some of them joined the backlash.

Furthermore, every Minister of Health since 1978 has consistently avoided providing leadership or support for nationwide application of the law. First, the Minister postponed the date for prohibiting re-admissions to psychiatric hospitals by three years, while appointing several commissions to examine the question. Then, although no funds were allocated over a 5-year period to implement the '180' (as it was called), ample funds were promised to implement proposals that would move Italy back toward a hospital-based system. But there were other obstacles as well.

Five years after its passage, it was possible to venture a typology of regions according to degree of implementation of the law. Those areas where the anti-institutional movement had been most active before 1978 (e.g. Trieste, Arezzo, Ferrara, Perugia) acted most in accordance with the spirit of the law.There, hospital populations were successfully reduced, and a network of alternative services, from work cooperatives to free-standing clinics to supervised apartments to group homes, continued to grow. In other areas, deinstitutionalization efforts were underway, but success still limited. This was true mainly in Northern cities such as Genoa, Turin, and Venice.

Finally, there were areas (especially in the South of Italy) where implementation of the law was practically absent, or worse, where it was applied in a negative way, guaranteed to provoke a crisis. In some provinces of the South of Italy patient censuses in large hospitals had been maintained or even increased, with special regional decrees postponing the date after which readmission would no longer be possible. Elsewhere in the South, deliberate misapplication of the law resulted in a form of 'dumping' that Italians call 'wild discharges'—i.e. patients literally bused off hospital grounds without any discharge plans

or material or social resources. As a result, homelessness seems to have increased in several cities.

The particular situation obtaining in the South of Italy deserves special attention, for the region has always remained locked into a kind of hostile, economic vassalage to the more 'economically developed' and politically progressive North. Non-compliance to national laws and programs has been one way in which provincial administrators have maintained their hegemony. So, for example, although the mental health law of 1904 had required each province to establish an asylum, in 1973 only three of seventeen Southern provinces had a mental hospital. Likewise, the 1968 Law ('Legge Mariotti') which called for the reduction of hospital populations to a maximum of 677 beds and which established community mental health centers, was barely followed. Some hospitals simply subdivided, creating 'two' hospitals as a way of circumventing the reduced bed criterion ruling.

In place of provincial public mental hospitals, the Southern regions had always favored an alternative: a system of private hospitals under religious auspices to which patients were taken from cities and towns all over the South, and where they were warehoused under minimal public supervision. Hence there should be no surprise that after 1978 funds for psychiatric hospitals were rarely converted into support for alternative, community-based services.

However, regional differences go beyond the North-South division. The law decentralizes the administrative level of psychiatric assistance, holding the regions responsible for planning. As of 1983, however, nine of the twenty regions in Italy had not yet designated preventive, rehabilitative, and treatment services outside the hospital (in the *'territorio'*).

Neglect, sabotage and incompetency in carrying out the law's intent can explain only part of the problem. It should be recalled that the law was a compromise measure and at least two structural aspects render it vulnerable to misapplication.

First, the only service that is specifically required is the Diagnosis and Treatment Unit (SDC), a ward of no more than 15 beds attached to a general hospital. Generally, such units are locked and rely heavily upon psychopharmacology as the treatment of (staff's) choice. By locating the service in hospitals, the very space determines their medicalized character. This certainly defeats the spirit and purpose behind Basaglia's and his colleagues' work in democratic psychiatry. And, because community services, which are not specifically mandated, have either not been funded or else are extremely limited in staff and in hours of operation, the SDC is the only facility in most places that people (or their families) can fall back on when they are in an acute phase of distress. Meanwhile, the 15-day limitation (originally intended as a protection to patients' civil liberties) has been subverted by the technique of multiple readmissions. In other words, the SDC has become a new 'revolving door' facility.

Second, the absence of adequate regulations, mechanisms and funding for community alternatives has tended to produce the distortion pictured above. Perhaps Rome exemplifies this situation the best. Plagued by typical problems of metropolises everywhere—unemployment and a large underground economy, immigration, shortage of public services, etc.—it has few community mental health centers for a population of almost four million. Members of democratic psychiatry would challenge the explanation that cost factors prevent the Italian community 'model' from being carried out on a wide scale, contending instead that community care and hospital care cost approximately the same. Nonetheless, the entitlements that allow an ex-patient to obtain housing and the minimum money needed to live outside the hospital are still provided primarily and unsystematically by the provinces. As a result, a major incentive to an adequate level of community living is limited by the lack of a universal entitlement, such as Supplemental Security Income in the United States.

By the early mid-eighties, a new block had arisen in opposition to the law. On radio talk programs and in the newspapers, families of patients pleaded their cause. Some asked for the public mental hospitals to be reopened; others joined with Democratic Psychiatry to push for an 'honest' implementation of 'the 180'. Family associations are most vocal in Rome. There, with a ratio of SDC beds to general population on the order of 2 per 100,000 and scarcely any other services, patients are either abandoned or left as a burden for the family to deal with, most often a wife or mother. Thus in a span of a few years, a visible segment of the general public has become a new force to which psychiatrists and administrators must respond.

Franco Basaglia: Legacies and Utopias

In part the legacy of Basaglia is with Democratic Psychiatry and with those community workers in cities where anti-institutional work continues. In part, his legacy is with alternative psychiatric workers throughout Europe, North America and Latin America who identify with the spirit of collective human decency, radical tolerance and deestrangement that were the hallmarks of Basaglia's vision.

Although conditions in the Italy of the eighties (as elsewhere in much of the West) are not the most conducive to a demedicalized and alternative practice of community psychiatry, as the economic crisis has taken its toll on jobs and housing, and as cutbacks threaten social services and the new health system, there are still grounds for guarded optimism, Basaglia, himself, had warned against the anti-institutional movement being nipped in the bud; yet he also grasped new possibilities emerging. With respect to the passage of law 180 he said:

> Even though it is the fruit of a struggle, a law can only be the result of the rationalization of a revolt. But it can also succeed in diffusing the message of a practice, rendering it a collective heritage ... it can diffuse and homogenize a discourse, creating the common bases for subsequent action ... [23].

Certainly the gains made by all the Italian social movements in the decade following 1968 were nothing short of astounding: a national health service, anti-pollution laws, the gradual elimination of asylums, free continuing education (the '150 Hour'), and a long list of victories attained mostly by the feminist movement: legitimization of divorce and abortion, publicly-funded day care, reform of family law and women's health clinics. New forms of protest and politics had won nothing less than an expansion of citizen's rights, an increased participation in government, and a multiplication of social services. Italy had moved from an old system of charity toward a more modern welfare state model guaranteeing universal rights, not only to the traditional groups linked to production (workers and their families), but to the various marginal groups—the 'emarginati'—that had appeared.

Once stereotyped as a 'backward' and 'backwater' European nation, a second class citizen in the world economy, and stigmatized by the persistence of some archaic social forms, Italy in the last decades of the 20th century has emerged as a truly modern, humane and cosmopolitan society, a world leader in progressive social reform, of which Basaglia's anti-institutional movement represents its most daring and dangerously fragile creation. Paulo Freyre once remarked mischievously that North Americans have had to turn increasingly to the materially depressed Third World for spiritual inspiration, specifically to Brazil and Central America, to discover a rejuvenated and vital theology of hope and liberation. So, too, dispirited community psychiatrists in the United States, Canada and Great Britain might question their ethnocentric assumption that progressive social movements always

originate at the core of the industrialized world. Instead of prematurely declaring deinstitutionalization policy a failure, they might well pause for a moment and turn their attention to the semi-periphery—to Italy—for a rejuvenated psychiatry, a psychiatry of hope, a psychiatry turned *inside-out.*

As we conclude this essay (Anne Lovell in New York City, and Nancy Scheper-Hughes in Berkeley), we would be altogether remiss were we not to reflect, finally, on the status of deinstitutionalization in the United States, and on the plight of the homeless—many of them ex-psychiatric inmates—who are sometimes *quite literally* at our doorsteps. With respect to Basaglia's legacy, what message, what lessons are there for an enlightened practice of psychiatry outside asylum walls in our own embattled cities?

Lessons for the United States

> No possible alternative to the institution exists unless it is a constant and practical critique of every form of institution: the mental hospital to the mental health system, from the center to the neighborhood [24].

At approximately the same time that Basaglia and his co-workers were 'destroying' the institution at Gorizia and 'deconstructing' the logic behind institutional psychiatry, Governor Ronald Reagan was blithely closing down state mental hospitals in California, preparatory to a total 'pull-out' of public responsibility for, and commitment to, the plight of the 'chronically mentally ill'. Although there were many different rationales behind the policy of 'deinstitutionalization' in the United States (medical, social scientific, ideological) [25], what motivated Governor Reagan (and other public officials elsewhere) was a concern to save his tax-paying constituency money. He was quite prepared to increase the public coffers by consigning public mental patients to the streets. This particular American social tragedy, then, begins and ends here, with a policy founded on a distortion—a promise to 'humanize' and 'communitize' care for the mentally ill by reducing the State's financial commitment to them.

American deinstitutionalization was the result of several factors converging from the mid-1950s on. For one, the existing physical plant of the public asylum system—a legacy of the 19th century—was rapidly approaching a state of total decrepitude that made their renovation or replacement mandatory [26]. Then, during the next two decades, civil libertarians and patients rights activists would gain landmark legal cases to push their cause against the conditions of psychiatric institutions, if not the very nature of confinement and psychiatric treatment itself. Wyatt *v.* Stickney, in 1972, established guidelines for upgrading Alabama's notoriously punitive and repressive mental hospitals—from improving patient-ratio staff to the purchase of bed sheets to the building of new toilet and shower facilities. A few years later, a case won by a long-time hospitalized patient Kenneth Donaldson, made involuntary commitment and treatment more difficult to enforce. Regardless of the political climate in which these battles were fought, judicial decisions were implemented in such a way as to favor deinstitutionalization, as both a humane *and* a cost-saving policy of reform. The availability of new forms of income maintenance that could be used in the community and in other types of institutions, such as nursing homes and adult residency programs, gave further impetus to the transfer of patients from mental hospitals to the community. Medicaid, which could not be used in psychiatric hospitals, had a similar effect.

Beyond these basic fiscal considerations, however, lies even more potent political issues, especially those concerning the control of social deviance. It has been suggested that the mental asylum had outlived its usefulness to the State and that it represented an archaic

institution of social control, inappropriate to the needs of an advanced capitalist society such as the United States in the late 20th century [26]. Although North American psychiatrists had readily taken up the task of managing the huge state-run 'monasteries for the mad' (as Andrew Scull calls them), they were never, as a profession, totally committed to this particular psychiatric practice. The mental asylum has coexisted for at least half a century with 'softer' forms of intervention and control- -psychotherapies, mental hygiene programs, community-based care. But it persisted for the control of the less tractable and the more hopeless psychiatric cases. American psychiatrists were among the first to suggest that the advent of modern psychotropic drugs in the 1950s rendered long-term institutionalization superfluous [27]. With new outpatient compulsory treatment laws replacing earlier involuntary commitment laws, deviance and madness could now be controlled where they first occurred: in the community. And, given the proliferation of 'psychologies' and medical and social work professionals operating at street-level, the circuit of social control could be further extended and diffused throughout the city. It could be said that we have exchanged tranquilized wards for tranquilized ghettos filled with poor and homeless psychotics whose only resource is a weekly shot of Prolixin at a storefront clinic.

In Foucauldian terms we have entered a new episteme in the long history of the (mis) treatment of the mad in which punishment and seclusion have given way to regulation and surveillance—or even to self-regulation and self-colonization. This is certainly *one* interpretation we might give of the new population of so-called 'Young Adult Chronics' who learn to survive by 'making it crazy', as Estroff writes of her sample of drug-dependent 'street crazies' who bounce off and between day hospital and night shelter, between drop-in clinic and drop-out training programs [28]. With their only form of dependable subsistence (SSI) tied to a damaging and chronic diagnosis, it is little wonder that in the bustling, impersonal marketplace of life on American streets, ex-mental patients now 'traffic' in illicit symptoms, trading their illness for the semblance of economic security through welfare for the 'totally and permanently disabled'. And so we have chronicity born of economic necessity, a new possibility for existence determined by the social welfare bureaucracy.

An alternative Basaglian view might lead us to explore the forms of resistance that also occur within this homeless street population where alcohol and street drugs are often used defensively in place of tranquilizing neuroleptics and psychotropics, where an intimate knowledge of the city and its surrounds can sometimes provide a protective camouflage that defies even the most experienced police and other street-level agents of social consensus, and where welfare 'abuse' can be understood as a rare act of autonomy in an otherwise altogether desperate situation. We realize, of course, that these are marginal and often self-defeating survival strategies, and we would not want to fall into the easy trap of romanticizing the 'culture' of the streets or minimizing the suffering of the chronically afflicted and disoriented.

Indeed, the very *public* nature of madness and vagrancy on our public streets—as the poverty of the asylum joins the poverty of the streets—recreates a modern substitute for Jeremy Bentham's Panopticon. Bentham's design for the perfect nineteenth century total institution was one able to induce in the inmate a sense of conscious and permanent visibility, an arrangement of space that rendered him a perfect object of continual surveillance. In his *Discipline and Punish* Foucault describes the Panopticon as a

> machine for dissociating the see/being seen dyad: in the peripheral ring, one is totally seen, without ever seeing; in the central tower, one sees everything without ever being seen [19].

Visibility has become a trap, a new metaphor of powerlessness. Likewise, if the new population of so-called homeless mentally ill is said to be an 'eye-sore', this of course

implies that they are rendered the objects of our discriminating, incriminating, hostile gaze. Surveillance is no longer contained within a perfectly rationalized architectural space; its gaze is polyvalent, its viewers a multiple public, the colonizers of those street people who transgress a newly privatized terrain. Deinstitutionalization has occurred in the United States during a period of rapid gentrification and privatization of the commons. By this we are referring to the transformation of once public domains—churches, subways, parks, squares—into extensions of private space, so that neighborhood 'homeowners' can express a kind of righteous indignation at the very presence of 'vagrants' and 'derelicts', as if the homeless were violating their own living rooms when they pass time in public. It is as if there were no longer any neutral ground. In New York City the renovation of Times Square, of the grounds behind the New York Public Library, of Union Square are designed to make these public spaces inhospitable to vagrants, the homeless, the propertyless. In San Francisco the construction of new city parks is likewise designed to discourage the homeless from thinking of themselves as part of the public. For example, Boedekker Park, created out of the corner rubble in a section of the run-down Tenderloin district, is said to "demonstrate the gentle art of landscape architecture ... in taming the urban jungle" [30]. Its special 'safety features' include high visibility (it can be seen entirely from the street—there are no trees or shrubbery that might conceal 'derelicts, drug dealers and low life'): 175-W bulbs stationed every 40 ft; a 6-ft high fence and gates to keep out night visitors; and short benches with arm rests to prevent 'anyone but a midget' from sleeping there. Finally, a Recreation and Park Department staff member will be on constant 24-hour surveillance duty.

Despite the perhaps only partially recognized possibilities for new forms of social control implied in the harboring of a vulnerable and exposed psychiatric street population, both professional and lay public discourse now descries the 'failure' of deinstitutionalization. A new 'humanitarian' rhetoric has arisen that condemns the 'dumping' of asylum wreckage on city streets, and that calls for a reexamination of the old institutional solutions for managing those who seem unable to manage themselves. The APA task force report on the *Homeless Mentally Ill,* released in the fall of 1984, refers to deinstitutionalization as a 'major social tragedy' and the group reached "... agreement on the need to change the laws in order to facilitate involuntary treatment" [31]. Similarly, letters to the editor and opinion columns in newspapers throughout the country increasingly carry calls for the 'clean sweep' of bag ladies and grate gentlemen, and for a return to long-term, custodial care. New legislation recently introduced in California would make compulsory treatment easier and would create the legal status of 'involuntary' out-patient, i.e. the coercively tranquilized.

There remain, however, a small but persistent group of social scientists, community psychiatrists and patients' rights activists who believe that deinstitutionalization has not failed, because it was never really attempted. Insofar as the closure of state hospitals was never accompanied by the 'opening up' of communities, and in the absence of any redefinition of the meanings of 'mental illness', or any redefinition of psychiatry as a social practice, deinstitutionalization merely reproduced in the local setting the same exclusionary, institutional logic that was the very foundation of the public asylum system.

The myth is that U.S. mental patients were returned to community life; the reality is that 'community' was defined as *any* setting outside the grounds of the state mental hospital. What really occurred was a transfer of mental patients from state-run hospitals to federally supported or privately financed community-level institutions. Locked, skilled nursing facilities—the most common alternative placement for the elderly, senile or incontinent ex-mental patient—constitute, in many cases, a more restrictive and punitive environment than the often spacious 'campuses' of state asylums.

The myth is that mental patients have been returned to their families; the reality is that few ex-inmates have been taken in by their relations. In fact, American families have grown more vocally opposed to deinstitutionalization, and some have formed their own parent or family support groups to block plans that would return their needy and dependent relations to their care. With the demise of state responsibility for the 'chronically mentally ill', and as American families of ex-patients have refused to take up the burden of their parents and children, fertile ground has been created for a 'new trade in lunacy', as Andrew Scull refers to the modern scandal of private 'Board-and-Care Homes'. Ex-patients, alone, disoriented and needy, are unable to make informed choices and so fall easy prey to a host of new and enterprising 'penny capitalists', speculating in human misery. The Board-and-Care Homes operators offer food, shelter and a promise of protection for the ex-inmates often thrown into a hostile and rejecting inner city or working class neighborhood. Many of these so-called 'homes' are, in fact, full-blown, but largely unregulated institutions warehousing as many as two or three hundred ex-patients as cheaply as possible. One can only speculate as to the 'quality of life' offered in these new community-based madhouses, and whether they offer any improvement over life in the back wards of the state asylums. Today, in San Jose, Calif., for example, there are more than 1000 board-and-care homes in the dense and deteriorated downtown section alone.

Among the 55 middle-aged chronically distraught psychiatric patients who had been released from Boston State Hospital and returned to their white, ethnic, working class community in south Boston, studied by one of us (N.S-H.), many were living in non-institutional settings, but their daily lives were highly regimented through their daily attendance at a day hospital, rehabilitation programs or sheltered workshops. In fact, these ex-patients functioned almost entirely within the decentralized mental health system, punctuated by occasional readmissions to the state hospital. Rather than a toe-hold in the difficult transition from hospital to community, the day hospital and sheltered workshops had become a *permanent placement* in the community, their only 'ecological niche'. In this traditionally Irish-American neighborhood of south Boston, the transfer of care for the chronically disoriented passed, in part, from State to Church as the Boston Archdiocese began to reopen only recently closed convents and rectories as half-way houses and community residences for the deinstitutionalized, in some cases supervised by the few remaining religious Sisters. As one parish priest wryly summed up the current situation: "The Good Lord must have known when he had us building all those Catholic schools, and parish houses and convents in the 1950s, that they were meant to house all the drifters, and crazies, and drunkards of the 1970s". These Church-affiliated community placements (although often austerely and monastically run) were, in fact, highly valued by the ex-patients of Boston State. As one said:

> All my life I've been poor and needy and sick. I have to keep it in mind that whenever my relatives see me, they're going to think, 'here comes trouble'. I always cost them money. But living here, under the protection of the Catholic Church, I'm *somebody* for the first time.

Another, and much less benevolent 'community' institution that has taken up the slack created by the State's massive pull-out from the Mental Health Industry is the criminal justice system—i.e. the prison. In the last decade the prison population in the United States has risen by 80% to an unprecedented national census of 350,000 prison inmates. Several prison surveys have reported the appalling increase in the numbers of psychiatrically disturbed inmates. An earlier phase in the history of the treatment of the insane seems to have returned, full-circle, as 'madness' once again is recast as 'badness' and as prisons are accepted as appropriate institutions for housing the disturbing and 'presumed to be dangerous' social deviant.

In the states of New York, Massachusetts and California where 'wild discharges' and casual dumping have been most pronounced, a new, particularly jail-prone population has emerged: the young adult, male, transient, destitute and desperate, as well as angry and disoriented (psychiatric) street person, 'space-cases' in Berkeley street parlance. To mental health professionals they are the so-called new Young Adult Chronics [32], the bane of social workers and psychiatrists alike. What makes this population difficult is, in part, the historical context in which they came of age:

> Their relationships with institutions have been formed in an era of civil rights and consumerism. Few have experienced long-term hospitalization, and few exhibit the apathy, lack of initiative, or the resignation that numerous studies found to characterize the long-term mental hospital resident. These 'new' chronic patients *have not been socialized to docility, to the role of acquiescent* mental patient; they do not use services in the tractable fashion of their predecessors but rather as wary, often angry consumers demanding response to their broad needs for social and economic support [33] *(editors' italics).*

Worse, to add insult to injury, the authors note that today's younger chronic patients "... tend to resist the contention that they are mentally ill". In short, we have a population not yet destroyed by institutional treatment and logic, but without an alternative community psychiatry—such as Basaglia's democratic psychiatry—to recognize the legitimacy of their complaints and to channel productively and politically their anger and aggressivity. The result is tragic. Prison, asylum, board and care home, shelter, street—these are the components of the new circuit of control. In this case, surveillance is often the only response given to human suffering and need.

In 'liberal' Berkeley the huge psychiatric street population of 'space cases' are less than benignly neglected, while in nearby Santa Cruz, the street people are called 'trolls'—because of their tendency to seek shelter under bridges—and they are harassed and physically assaulted by college student vigilantes calling themselves 'troll busters'. They provoke street fights that often lead to the arrest of the more vulnerable group.

Before, however, the resounding failure of American deinstitutionalization is recognized as a foregone conclusion, and before plans for the reinstitutionalization of the 'mentally ill" are in place, we might consider the lack of planning and the absence of a unifying ideology that contributed to the current situation. At the very least we need to re-examine our operating assumptions and to (radically) reformulate our current practices.

The Italian experiment, although flawed and riddled with its own inconsistencies and contradictions, offers evidence that deinstitutionalization can be done differently and with considerable success. To what extent, however, the Basaglian program and ideology can be exported or imitated in other contexts is debatable insofar as the Italian experiment—where it succeeded—did so *exactly* because it was able to articulate with the vernacular culture, with the anti-authoritarian and communitarian ethos of large segments of the Italian working *and* professional classes.

What would it take to apply something analogous to the Italian experience in the United States? Certainly, many of the ingredients of success in Italy are lacking: a professional leadership committed to radical change; a cultural and political environment open to sweeping social reform; a political conception of madness as alienated human needs; a healthy mistrust of the objectivity of science and the neutrality of the social and medical professions; a popular consensus in sympathy with anti-institutional principles; a coherent and universal health insurance program covering both medical and social services. While Basaglia and his co-workers developed alternative solutions in politicized cities, such as Parma, with the help of communist party leaders and labor unions, such organized bases of support can hardly be expected to be forthcoming in middle-American cities

and towns. Meanwhile, with few exceptions, charismatic leaders in psychiatry have yet to appear on behalf of the deinstitutionalized homeless and communityless in the United States and Canada. Yet, within the vacuum left by the absence of an enlightened and energetic psychiatric professional leadership, what *has* arisen is a plethora of citizen and self-help advocacy groups—patients' rights movements and grassroots coalitions for the homeless [34]. These are *our* special cultural legacy of the identity politics that emerged during the 1960s, and what these groups are demanding is no less radical than Basaglia's anti-institutional, demedicalized, and deprofessionalized response to the unmet needs of the alienated mad-poor.

In sympathy with these creative, if widely scattered, 'counter-psychiatry for the people' groups, we could at least see to it that our communities are organized so that the deinstitutionalized, but still distraught, could always find a place to sleep, meals, basic health care *without strings*—i.e. without obligatory and mind-altering chemotherapy, painfully intrusive psycho-therapies or degrading, menial sheltered work [35]. Our reading of the results of numerous outcome studies for deinstitutionalized individuals leads us to the conclusion that the safest, most protective environment for the deinstitutionalized, but still chronically psychologically afflicted, individual is one characterized by: a high tolerance for difference; a low expectation for *conventional* productivity, mutuality and reciprocity from the ex-psychiatric inmate; within a caring, but non-institutionalized setting. In other words, with Basaglia and his equipe, we agree that, above all, *'Freedom is therapeutic'*. Such a regime would require a transformation of cultural norms about the limits, the parameters of the 'normal', the 'acceptable.'

Insofar as a fundamental characteristic of madness is a refusal or an inability to participate according to the 'commonsense' ground rules of everyday living, this new spirit of tolerance would require an acceptance of some disorder, chaos, unreason in the speech, thoughts, actions of the so-called psychotic individual. It would mean a surrender of our reality-centric world view and an acceptance of the subjective experience of alternative realities. Following Michel Foucault's early analysis, a necessary requirement for social reintegration would be a willingness to 'give madness back its voice' [36]. In Basaglian terms, this means an empowerment through words, an understanding that even 'delusional' or 'delirious' speech may be a febrile voice of protest, the only possible act of resistance and autonomy available to a silenced and excluded population.

Perhaps the greatest existential problem faced by the population of psychiatrically distraught and homeless is that of finding a space where they can legitimately *be* during the day [37]. They are suspect in public parks and on city benches, unwanted in libraries and churches; the time they can 'hang out' in donut shops and cheap diners is limited. Many attend day hospital programs and conform to the medicalized regimes offered there only to participate in the free lunch program and to have a place where they can 'hang out' unharassed. The psychiatric policy of abandonment is expressed most flagrantly in the current wave of homeless persons who include among their ranks many who in an earlier era would have filled the wards of state hospitals.

In the current debate over housing vs mental health services for the mentally ill homeless (well documented in the American Psychiatric Association's Task Force Report) the side to choose should be clear. While housing alone can never suffice or substitute for the broad range of social, cultural, political and individual responses to human suffering and afflictions of various kinds, it is, at the most basic survival level, a mandatory requirement. And so we have in mind, as a *minimal* program, the establishment throughout the United States of a network of hostels where the homeless, the vagrant—especially those younger and more desperate populations set adrift, one way or another, by the closure of

hospitals and by 'dumping'—might find a place to live, to participate in community life with a minimum of externally imposed or institutionalized structure. These permanent hostels would bear some resemblance to Basaglia's *ospite* or guest quarters at Gorizia and Trieste, implying a new legal status for an *autonomous* although perhaps economically dependent population. These hostels would come to replace the current and inadequate hodge-podge of 'emergency shelters' functioning unsystematically in most American cities.

The lack of housing faced by the current population of displaced and distraught homeless is a problem of chronic dimensions, not one that can be solved by recourse to makeshift, first come-first serve flop houses. Segal and Baumohl, who have been following the Berkeley street people for several years, have concluded that

> Like unemployment, 'unhousing' is a problem of political economy not amenable to simple tinkering with the victims ... Without [the building of low-income housing or residential hotel units], shelters will become long-term encampments of the poorest citizens regardless of social work interventions [33, p. 115].

And they have proposed, in addition to the provision of low-income housing, the creation of another kind of protected space for the 'young chronics': the 'community living room'. They envision a network of non-residential store-front living rooms that would offer street people refuge, companionship, and basic survival services: a place to 'hang out', to receive mail, make telephone calls, cash checks and get paralegal services and social casework management and advice. Finally, the community living room programs—a kind of indoor 'People's Park'—would offer daytime shelter and meals. We see this proposal as also participating in the collective spirit of Basaglia's anti-institutional program.

But beyond these basic survival needs, the deinstitutionalized homeless will eventually require some real economic contractual power within the community: the opportunity to work for fair wages in alternative and creative capacities that recognize not only the limitations and disabilities of the 'chronically mentally ill', but also their particular talents and abilities. This does not mean 'sheltered workshop/sweat shop' environments, but work through public and community programs in education and the arts, in construction and computer programming, in parks and recreation, wherever the individual talents lie.

In addition, the deinstitutionalized and displaced require someone who cares about them—not as a doctor or a social worker cares about a client—but as one family member, one friend, one colleague cares about another: freely and spontaneously. What is needed are the stream of *'Basagliani'*—the volunteer college students and housewives, artists and artisans, working people and the retired (those like the townspeople of Gorizia, Trieste and Parma)—who rose to the occasion and came out to welcome the ex-mental patients back into the human community. This entails a redefinition of community, meaning not merely any geographical location outside hospital grounds, but a Basaglian conception of community as gemein-schaft or 'communitas'—a community of mind and will and spirit, a physical, psychological and social space where the suffering and non-suffering, the conventional and the uniquely different, can both find a home. Finally, what is needed is an American variant of Marco Cavallo, a unifying cultural symbol that encompasses a new psychiatry of hope for ex-patients, their families, their co-workers and co-residents. We need to allow madness to emerge from behind the medical mask that has concealed its most social properties: the cumulative effects of rejection, exclusion, and stigmatization. We need to look madness in the face and to recognize ourselves in the play of contradictions that is revealed there.

Susan Sontag writes at the beginning of *Illness as Metaphor* that

> Illness is the night-side of life, a more onerous citizenship. Everyone who is born holds dual citizenship, in the kingdom of the well, and in the kingdom of the sick. Although we prefer to use only the good passport, sooner or later each of us is obliged, at least for a spell, to identify ourselves as citizens of that other place.

She is expressing here the intense feelings of marginality, exclusion, experienced by the afflicted, especially by the stigmatized afflicted—those from whom it is all too easy to turn away in disgust, revulsion and pity. It is also, however, a sobering reminder that each of us ambulatory, sane, 'whole' individuals holds only a temporary truce against illness, madness, suffering, exclusion, and death. We are, as Sue Estroff likes to remind us—the temporarily able, the temporarily sane [38]. It is an essential truth that Basaglia and his co-workers were able to convey to a large populace in Italy. Another was the reminder that a person's differentness, her malaise or her suffering is not legitimate grounds for her ostracism, exclusion, and confinement. Democratic Psychiatry, as developed by Franco Basaglia and his co-workers, implies the creation of a social space in our communities where those who are the veterans of intra- and inter-personal conflicts, of mental prisons and of medical wards, can coexist with, and not apart from, the rest of us.

A member of the film collective that produced and distributed the documentary, 'Fit To Be Untied', summed up the anti-institutional movement when he explained [39].

> What we were trying to say is just this: community life is like a banquet table. We wanted to make sure that everyone has a seat at the banquet.

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