Trieste 2010: WHAT IS 'MENTAL HEALTH'?
Towards a global network of community health
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Introduction

With each passing day, the conditions of social inequality, and the uncertainty, universally recognised, existing in all fields and with respect to every value, are increasing. This situation tends to level and reduce the interest and margins for a critical discussion on the question of the relations between people and between people and institutions.

This is a difficult period for the processes of institutional change and the increase in rights. However, there is the felt need, on the part of many, to revive a cultural debate and create a common platform which will enable us to feel less isolated and recreate the conditions for a common effort.

The Mental Health Department of the Local Healthcare Services Agency n°1 Triestina, is therefore organising an occasion for encounter, exchange and discussion aimed at the creation of a Global Network for community healthcare, based on the commitment to innovation and the transformation of services and institutions, and on equality and the recognition of rights in healthcare processes.

A paradigm shift, between rights and institutions

Despite the contradictions of the present time, characterised by the shrill debate among psychiatric and medical paradigms, and the coexistence of scientific and humanistic approaches which are, at times, polarised, conflictual or fragmented among different specialisations, the possibility of a paradigm shift remains.

On the one hand, there is the neo-positivist and reductionist view of 'illness' as a mere biological fact, a notion which persists and periodically finds greater support in the scientific community. On the other, the knowledge gained in the course of deinstitutionalisation processes regarding the complexity of each person's existence-

suffering, and thus focused on the subjective needs of recovery and social inclusion. Until now, there have been few attempts at dialogue or exchange between these two opposing camps, and within the framework of this complexity which, however, continues to be present in all its problematical aspects. Such dialogue is not the norm in research or theoretical synthesis, nor in the area of practices and concrete responses to the persons themselves. Nonetheless, innovative epistemological approaches are not lacking, from the historicity of the biological in its connections with contexts and experiences, to a concept of the organism as a complex system, to integrated bio-psycho-social models of vulnerability and illness.

What do we mean by "mental health" today? Can it be defined based on its diverse meanings for users and care systems alike, thereby distancing itself any form of reductionist psychiatry? Can the person who suffers be given opportunities for care and emancipation processes, even where rights are weak or absent?

The question of universal human rights – to health, citizenship and free expression - is always raised within the context of specific forms of knowledge that, directly or indirectly, legitimate or invalidate the demand for such rights. Dominant forms of knowledge, such as medicine and psychiatry, often joined with ideologies of exclusion, continue to perpetrate 'peace crimes' through total (and other) institutions.

In Italy, following the closing down of asylums, and especially over the last decade, new forms of harm and abandonment have reappeared in hospitals, private clinics and residences for chronic patients, but also in community services. These institutions reproduce, albeit in different forms, the dehumanisation of psychiatric hospitals.

In the generalised de-hospitalisation of psychiatric care which has taken place worldwide, the axis of care based on custody-control has shifted only partially from the hospital to the community, from institutions to services and from the illness to the person. Instead, there has been an increase of institutions for specific forms of reclusion, in a logic of the control of behaviours within psychiatric-forensic or 'special' containers (or prisons *tout court*), with psychiatry once again providing guarantees through technical-scientific justifications. The old notion of danger has been updated to that of 'risk', and as such reappears in the new social-community, or 'neo-clinical' psychiatry, where the concept of illness remains essentially unchanged.

However, despite the persistence of forms of institutional reclusion, violence, abandonment and the denial of rights (which in old and new asylums alike, continue to be perpetrated by those who are either wilfully blind or prefer to ignore the evidence) much progress has been made, and the overall trend is positive, as confirmed by the currency of certain key-words and concepts.

Today, there is a widespread awareness that reforming services through legislation is not enough. Community and personal resources must also be activated, and in a way that changes the services themselves.

The whole life approach, which is rooted in the experiences of community mental health users and operators, and posited on personalised care and recovery projects, has become the cornerstone and paragon for many care programmes and systems.

'Integration' is a key-word widely used to describe a continuum of care and support systems. But integration also means promoting inter-subjective relations within a wider

political dimension. It means integrating social and healthcare interventions, and recognising the social determinants of illness and healthcare processes based on a 'whole life' approach to the person. And mental health is not the only area that must assume this commitment, for 'there is no health without mental health'.
Healthcare practices can be viewed in terms of care policies and systems and/or in terms of persons who are at risk. Psychiatric users can be allied with those who risk social exclusion, the disabled and the long-term ill, all those who not only do not have adequate access to full citizenship and healthcare-social welfare systems, but who often do not even enjoy the most basic human rights.

The focus on general health and the development of community services capable of delivering community-based healthcare (in Italy, the Local Healthcare Districts) within a wider strategy for expanding the enjoyment of social and other rights, has been seen as deriving from the lessons learned and the needs that emerged during the reform of mental health.
Equating mental illness and disability, in order to provide welfare guarantees, creates the risk of invalidation that can render recovery processes more difficult. Similarly, the assimilation of mental health into general healthcare can only occur if the medical paradigm changes and the negotiating power of the user and his/her social-family context is enhanced.

Comprehensive community mental healthcare systems
The paradigm shift from old institutions to full rights raises numerous issues.
We want to address these issues through the testimony of those who have enacted some exemplary experiences for the comprehensive transformation of mental health policies and practices. We are referring to experiences which attempted to construct coherent, integrated community systems that respond to the needs of a specific population and territory. And while an enormous gap exists between developing and industrialised countries, in terms of access to care and treatment, the human and social resources which can be activated are equally enormous, as was confirmed by numerous pilot-experiences.
In view of the healthcare principles announced by major international organisations – at Alma Ata, Ottawa, Helsinki etc. – what criteria can be used to determine if specific local, regional, state or national experiences and policies conform with these principles?
Beginning with local mental health, to what extent was it possible to create a level of inter-sectorial integration and collaboration among services, and between services and a specific NGO, so as to guarantee a systemic impact/approach to community healthcare? What were the key elements involved?
In what way is a systemic approach to healthcare not limited to merely creating a system of services? What are its strengths, sources of energy and components?
Is it possible to create a comprehensive healthcare system for a specific community which can respond to the healthcare needs and personal aspirations of users, while promoting health in the community as a whole? And if so, how?
How can a community's human, economic, social and cultural resources be activated, mobilised and co-ordinated in operational terms? Are there mechanisms which can

guarantee economic sustainability, especially in poor countries?

Experiences and innovation

In order to respond to these questions, we must first analyse the main tensions and contradictions existing everywhere in healthcare today, and which underlie and give rise to these same issues.

The poles or oppositions between which existing policies and practices lie, and which produce these contradictions, can be identified as follows:

- the strategic centrality of political-healthcare governance vs. the centrality of the general population; professionalism vs. the inclusion of all main stakeholders;
- clinicalised, specialised, centralised, hospital-based and institutionalised services, based on separate healthcare services and aimed at specific pathologies vs. integrated, comprehensive, decentralised, small-scale, low-threshold services, which are closely linked to social-living contexts and the local community;
- a budgeting system based on individual services and DRG vs. a personalised integrated budget, which aims at balancing costs between hospital and community, healthcare and social services (between healthcare and social service in Italy);
- the scarcity of institutional resources vs. the enormous potential energy for health to be found in the community, if services are capable of catalysing and activating them.

From these can be derived a further series of questions:

- is the mental healthcare system separate from or integrated with the general healthcare services? Is it organised in specific service locations/structures or is it provided within the community?
- are services generalised or specialised (functional teams, based on teams which respond to a target population)?
- how is this tension between the community and specialised services resolved? Between home care and structures? Between contexts and persons vs. professionalism and technicians?
- are there places for acute and crisis care outside of the hospital?
- are "user-led" programmes, where service users play a leading role, and the third and fourth sectors (i.e. local social services, NGOs, associations, social coops, non-profit groups etc.) effective partners, co-decisionmakers and co-managers in the healthcare system, with the aim of promoting a more democratic participation?

Despite the increased medicalisation of daily life and the multiplication of diagnoses and their related therapies, resulting in a steady pauperisation of the meaning of individual suffering, a series of experiences have shown that it is possible to activate healthcare services and systems focused on the person and oriented towards recovery.

To what extent can these experiences be confirmed by scientific evidence-based studies? (i.e. by quantitative and epidemiological, but also qualitative research based on personal experiences which demonstrate the effectiveness of community healthcare practices and specific intervention methods).

At the same time, the question of what evidence is and what producing evidence means can no longer be avoided. A critical examination of evidence-based medicine is needed,

which addresses issues such as the trend towards excessive medicalisation, technocracy, the participation of science and medicine in political-economic blocs, healthcare policies linked to performance indicators and the involvement of knowledge experts in government decision-making and the choice of technologies. Do all stakeholders have a voice? is there a real effort to promote public awareness concerning these issues? are true 'health' indicators drawn up and adhered to?

Crisis and human development

The current historical-social situation, characterised by the present social and economic crisis, is redefining macroeconomic standards and goals, and the standards for social cohesion. The crisis poses major questions regarding personal and collective security, lifestyles, values and the possibilities of survival. The general issue of society and risk seems to be absorbing and redefining the psychiatric question, relocating the paradigm of danger within the more general issue of 'diversity', seen as a threat and not as the challenge of integration.

The personal crises taking place within the global one, contain either the possibility of new solutions or a return to institutional expulsion, anomie and social drift, and the loss of even the most basic rights, such as the 'ownership' of one's body. One hears of a "medical citizenship" reserved, in affluent countries, to those who can be cured thanks to a form of trafficking in which the body is the ultimate commodity (such as the sellers of organs in poor countries). It is hardly surprising that one of the 'reserves' for this traffic is to be found in the large asylums, full of persons without rights and sometimes even without names. Human trafficking also raises questions concerning new forms of slavery.

The global crisis underscores the need for a different development model, both for advanced capitalistic countries and those with low/medium incomes. Other issues include how to respond to emergency situations caused by "natural disasters", and by human, social and political conflicts and, more generally, on forms of social economy for healthcare and inclusion.

In the specific area of social-healthcare services, the question of resources is equally dramatic. How recover wasted resources, often squandered or diverted legally or simply left unused, and apply them to providing essential social and healthcare responses that reduce the increasing levels of inequality, and which are guaranteed for all, regardless of gender, ethnic origin and religion.

How free-up the human and professional resources present in the community and hospital healthcare services, and in local social services, linking them and creating forms of synergy with personal and micro-contextual resources?

How re-think the structures and places where care is provided, and how create social habitats that reconvert resources devastated by our society, beginning with the assets of the great institutions, including former asylum parks and grounds? What role could social enterprise play here?

How recover the ethical and political dimension in healthcare work, opposing those who commit 'peace crimes' against men and women, old and young alike, by experimenting innovative practices that benefit both the individual and the whole community?

How bring together and give effective form to the planning and practices that arise out of

individual and collective crises (economic and "natural" disasters, wars) and the daily life of our communities?

Towards the global network

Networks of innovators, regional experiences, individuals who often work in prohibitive conditions, pioneers and isolated outposts, known and unknown, national and international organisations which unite all the stakeholders involved: can this multiplicity of actors and organisations come together to discuss, find some points of agreement and, without losing anything of their identity, specific nature or history, draw up a common declaration of actions and intentions?

Such a declaration could make visible the potential existing today for overcoming the crisis and for recovery, and for the social and civic participation of all in mental healthcare which is not just 'community' but 'of the community'. It could provide mutual support, knowledge, opportunities for exchange and comparison. And it could provide a platform so that experiences of change which are "evident" and practicable, which can be described in their key elements and transmitted not only within the scientific community and among the various disciplines, but also to society at large, can become part of the practice and patrimony of all.