Individuals, social changes and psychiatric services: continuity and innovation

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Summary. Over the last few years, psychiatry has had to deal more in depth with the mutation of social frames and of problems expressed by the community, which has changed itself, in particular at a cultural level. The historical attitude of psychiatry, which is to combine a scientific approach with recognizing the rights of all individuals involved in the healing system, can be very helpful in keeping services in touch with the new needs of society and places the neurosciences in a peculiar position.

Key words: psychiatry, community psychiatry, human rights, professional identities.

Riassunto (Individui, cambiamenti sociali e servizi psichiatrici: continuità e innovazione). La necessaria riflessione sui mutamenti nel campo dell’assistenza psichiatrica impone un’analisi attenta dei loro elementi determinanti a livello culturale, disciplinare, tecnico e sociale. Tale intreccio costituisce la specifica complessità di ogni discorso sulla psichiatria, e sui conseguenti sistemi assistenziali, e contiene in sé la possibilità di recuperare la dimensione multidisciplinare e multicausale della sofferenza mentale. L’interrogativo attuale, se cambia la psichiatria o cambiano gli psichiatri, ha come risposta che solo le istituzioni e le professioni rigide e destoricizzate non mutano e che la difficoltà nello sviluppare un paradigma della sofferenza umana, che concili conoscenza scientifica ed etica del tempo, pone le discipline psicologico-psichiatriche in una posizione specifica nella sfida cruciale della modernità.

Parole chiave: psichiatria, servizi di psichiatria di comunità, diritti umani, identità professionale.

TOWARDS A REVALUATION OF “PSYCHIATRY” MEANING

The cultural, scientific and technical debate, which has developed over the last decade in our field, has forcefully highlighted the necessity of rediscovering the meaning of psychiatry. This comes at a moment in when practices are particularly contradictory, but also the social image of the discipline and professionals.

The necessity of making an effort to reflect on the changes taking place in our operative field – overcoming the anxieties of strictly disciplinary logic with the risk of reductionist leaning – is not in dispute, however it is not as clear (or common) whether the cultures and the practices of institutional psychiatry constitute a definitive change in the approach towards the entire field of psychiatric disturbances. It appears to us that this is a central problem, which originates from visions which are many times dichotomic on psychiatrists and psychiatry, social and professional roles, scientific statutes, techniques and praxis, trivialized by the lexical clash (certainly not semantic) between the denomination of “mental health services” and that one of “psychiatric services”.

We believe that psychiatry is faced today with the momentous transformation of its scientific statute, treatment role, its social legitimization, with the necessity of a strong and clear stand. A stand which on a par with that which lead to moving beyond asylums and to the birth of the system of community psychiatry, amid a simplifying tendency and the preconceived notion of the scientific and therapeutic complexity of psychiatric action.

If various factors – social, generational, part of the discipline and of the identity itself of professionals – push towards a reductionist position [1], great attention must continued to be paid to the indomitable nature of human beings, and their suffering/diseases, to unitary factors of any kind. Otherwise one risks reopening a useless, misleading and unscientific debate on the priority of one of the fields (bio, psycho and socio) when on each, contemporaneously and evermore, the history of health and sickness of every person is declined.

What worries us is the persistence in our sector of ideological assumptions, culturally limited and scientifically misleading, which through the services, techniques, the praxis and also treatment relationships, are at times determined more by the visions and aprioristic positions of the operators than by the needs of the patients.

A new scientific paradigm, in equilibrium between biologic matrix and cultural-philosophic matrix – without which not only does one lose the person, his/her world and his/her consciousness, but also...
his/her mind and brain – can only be assumed by operators and services able to overcome the limits of the auto-referencing, of the models which cannot be considered even when needs, requests and persons are by now “beyond” our instruments of recognition and response and call for profound and radical innovations.

In summary, we are speaking of a return to the roots of psychiatry – intrinsically connected to the human sciences, as well as to those biological. This in the effort to move closer and understand first suffering and then also the disease.

THE STRATEGY OF THE INTEGRATED APPROACH TO FACE MENTAL SUFFERING

This change/widening of the boundaries calls for reflection on intervention techniques and settings, in the effort of matching psychopharmacological, psychotherapeutic and psychosocial intervention with a truly integrated approach. An approach which should be made with attention given to the real scientific evidence (with neither suggestions nor obliging subalternity) but also to the production of clinical evidence (by means of case monitoring instruments, medical records as well as care reports and clinical audit systems), which support all of the levels of intervention (that is a clinical capable of producing evidence also on psychotherapeutic treatments and on the complex gamma of rehabilitative and psychosocial interventions, rich in cases and poor in systematizations, evaluations and monitoring of the outcomes on a clinical note and of the quality of life and social inclusion of the patient); on intervention settings, understood not only as locations, but also as networks, acceptance of patients and treatment, flexible with respect to the phases of the disease, to the objective of the treatment, to the contexts and the individuals. To consider and practice a clinical open to techniques, instruments, diversified interventions: from the medicine to self-help groups, through complex couplings but always understood as interacting parts of a single clinical idea and therefore of a “single and strong” course of treatment.

This approach moves beyond the limits of waiting (one takes on what comes along) and becomes active and of clinical action, capable of joining the “individual” approach and “public health” approach. Capable that is of defining priority, in the single treatment but also in the politics of the services: early intervention, intervention in adolescence and preadolescence, attention to the new psychopathological expressivity (personality disorders and/or behavioural of various types) and to the new subjects (elderly, immigrants, people guilty of crimes, situations of severe social deprivation).

But also, leaving space in this “lofty” concept of the clinical (under the technical profile, but most of all ethical) for the patient, his/her idea of diseases, his/her expectations, his/her placement with respect to the objectives. We find, along the way, the sense of the new approaches in the attention to adhesion to and active and conscious participation of the patient in the treatment (reducing the non-consensus or the refusal of treatment to certain moments in specific pathologies, phases or individuals and overcoming a culture still diffused in which the psychiatric patient, as such, always or anyway tends to be unaware of his/her disease), of the resistance to treatment (not reduced in a simplified manner to the lack of response to medicine, but more often intertwining of genetic factors – about which we can expect significant results from research in the field of pharmacogenomics, in the direction of the personalization of treatment – personological and of context), of the “recovery” understood as finding oneself and meaning, also in the experience of suffering and disease.

THE CONCEPT OF “RECOVERY”

In this view attention becomes primal to the factors of recovery and to the role, in this direction, of the services. The concept of complex and multidimensional “recovery” as its various meanings demonstrate [2, 3] originally [4] “imply a process of recovery or of development of a valid sense of belonging and a sense of positive identity beyond that of one’s own disability, and therefore the reconstruction of one’s life in the broadest community, despite the limitations placed by such disease”.

Recovery, understood as recovery of the consciousness of sufferance and of disease does not identify with clinical healing, but rather with that which is social (all considered an ambiguous and “grey” category) and with the experience of rediscovery: journey, re-signification, achievement of consciousesses, participation, active and lived citizenship, relationships of self-help and, most of all, not being solitary, inside or outside. A category which is not clinical, therefore, but a sign of the change of the relationship with the disease, development of new abilities to cope, reaffirmation of the subject as a person, in addition to and not contrary to the identity determined by the disease.

Services, in this direction, must assume a function of support and of catalyst. Network interventions, development of opportunities and possibilities of choice, appropriate and personalized care, capacity of listening and giving voice, flexibility of interventions, being there over long periods of time, knowledge of how to recognize and enhance health within and beyond the disease, being accessible, present and involved. All of these become instruments/routes directed at a “recovery-oriented” clinical approach, the strong points of which appear to be: a) not to stop at categories; b) to verify and systematize daily practices; c) reject the (pseudo) sure solutions; d) develop and promote independent education as maintenance; e) maintain the capacity of thought during upheaval and emptiness; f) establish relationships and services of “proximity”; g) transform rigid, fragmented, standardized practices into personalized, connected, shared practices.
We believe that today it no longer makes sense to question ourselves further about the dispossession of a Law which - though being object of bitter conflict - has anyway left its mark not only on the history of psychiatric assistance but more generally on health assistance in our country. It makes more sense in fact to look at what the actual requirements are for the improvement of and adaptation to new problems and new needs.

DEPARTMENTS OF MENTAL HEALTH: STRIVING FOR INNOVATION

Elsewhere [5-7] we have tried to tackle these themes, in the form of provocation – we hope useful – and in the search of responses on the front of the real and actual congruence of the organizational and functional structure of the DSM (Department of Mental Health) to the development of practices of community psychiatry and to the necessary innovations. Some operational guidelines appear suitable to represent the necessary process of system remodelling, assuming as essential the “organization - function” ratio: a) differentiate the products; b) work on the times and on groups; c) combat the stigma; d) be aware in order to make aware.

There is no doubt that we are assisting a weakening of territorial psychiatric services, which is manifested at the level of territoriality, represent-ability, of collective identity, of protection of rights. This situation calls for work which is not ordinary of the refunding of the culture and of the practices of the psychiatrist and of the mental health of the community, in order to be able to come out of an impasse which is also a crisis of values, ideas, projects, sponsorship, networks, sociality, sustainability, citizenship.

Careful reflection on the problems of today must begin with revision of work methodology of services: the public nature (in the sense of the responsibility, not necessarily of the provider); the territorialization of the intervention; the organizational model; the continuity and the specialization of the intervention; the multi-professional culture, the centrality of the work of a team; the active behaviour towards user, also toward those who refuse or interrupt treatment; the intervention in “borderline” areas and institutions (prisons, judicial psychiatric hospitals – ospedali psichiatrici giudiziari, OPG –); work for social inclusion and the battle against stigma; support intervention for family members and caregivers.

In our opinion attention has recently been opportunely called [8] to the phenomenon of re-institutionalization, determined not only by limits in the processes of deinstitutionalization (non-homogeneous and partial realization, fall from social attention to the rights to citizenship of vulnerable subjects), but also by demographic changes (elderly persons alone and nuclear families), by the weakening of the social capital and by the disinvestment in the relationships of assistance and accessibility.

A DSM more capable of intercepting and responding to the new questions must be: based less on the organizational structure and more on planning; able to develop connections and to move away from autonomy and isolation; integrated with public resources and accredited providers; flexible in the capacity of provision of and also of coordination with the other social-sanitary services, within and without of the ASL (azienda sanitaria locale, local health entity), centred more on the user, on his/her request and needs, than on the offer; in equilibrium between territorialization and specialization (geographic area, treatment plans for pathologies, free choice), between centrality of the psychiatrist and centrality of the case manager.

In this direction we are dealing with calling attention to the clinical pertinence (not only organizational) in a context which fully assumes the challenge of the complexity and of the intertwining of factors, transforming the discovery of the complexity in complexity method. The primary task of science, also in psychiatry, cannot be that of elaborating formal abstract models, but rather of trying to resolve human problems.

PERSPECTIVES IN PSYCHIATRIC FIELD

Faced therefore with a complexification of the scenarios, several paradigms which have oriented knowledge and practices in these years are revealed to be fragile and merit strong reconsideration. These include the definition of the actual and future field of psychiatric intervention from diseases to behaviours; the sustainability of the sophisticated technologies (for example, neuro-imaging and genetic research) in a view which always looks for the responses starting from the person and would maintain the centrality of an approach founded on the relationship and on the “human factor” technologies; the overcoming of the centrality of the symptom as objective of the intervention, without losing sight of the work of the explicating of life experiences and to give sense to the experience of sickness; the attention to the risk of a globalized nosographism/meta-cultural/meta-linguistic/meta-ethnic, which renders the differences similar and cancels individualities; a reflection on the changes in the social image of mental illness, of psychiatric patients and operators, in addition to the institution or the folly locked within it and simplified and in addition to the territory and the folly confused and camouflaged in it.

“... buried in language and in practices which are always more technicistic and bureaucratic … is found in the crisis, the urgency, in the explosive moments, in the chaos. It is the raw word which makes a problem for technocratic rationality, an invalidated word and rendered mute by the hegemony of specialized proficiencies. The subject it is not is the one who talks a lot, but is not understood.” (L. Blaise).
Elsewhere [9] we have tried to describe the everyday nature of the services through stories of persons and patients: Nneka, the “sans papier”; Alioscia, the adopted boy who is growing up; Evelyn and Rose Mary, the runaways from “who knows what”; Avito, the curious and ironic inventor; Giobatta, convinced that his doctor is head over heels in love with him; Giuseppe, who not even in a prison cell is able to let himself go… and even more.

The young and very young, women with and without children, psychiatric patients who become old and the old who go crazy, persons who have committed crimes, of all ages, social and cultural conditions.

The stories, and the reflections triggered by them, have not resolved our problem of professional identity, thirty years from the reform, but have served as an antidote to the ideological auto-referencing and – by now – also a bit pathetic. The central question seems to be, still today: how can we be useful but, most of all, where are we not needed? Nonetheless they have allowed us to grasp the sense and the value of several dimensions: the unorthodox meeting, the listening and in silence, the word rendered corporeal by the difficulty with verbal communication, action which speaks (doing something with) and even more. And this in meeting spaces without settings, that is without pre-established rules (and objectives, functions), to welcome and try to put together fragments of stories, persons, needs, memories, hopes, disappointments, failures, but also symptoms and diseases to treat. At times it seems one is welcoming castaways, who have come from “who knows where” or “how”, who carry the collective, cultural, existential, familiar, occupational, psychopathologic marks of survivors.

Perhaps the only possible route remains that of “monter et démonter sans cesse” always and anyway – as R. Castel [10] reminds us – an indispensable operation today, as much as it has been for the development of the processes of deinstitutionalization.

In this direction G. Tognoni [11], puts forward once again – “for a memory of content and methods” – the theses which were at the basis of the culture and of the ideal thrust of psychiatric reform: a) the overall stories of individuals – which include their life contexts and encounter/clash with institutions – are more important that their clinical diagnoses in determining the prognosis in terms of results; b) the institutional variables (presence or absence of services; quality, intelligence, organization of the operators; articulation of strategies of health assistance and non) are in fact the denominator and the vessel which allow single clinical interventions – diagnostic, therapeutic, rehabilitative – to be configured as an effective responsibility taken for problems, characterized by a natural story which is declined and decided over time; c) the quality of the services is in proportion to their capacity to guarantee cross-sectional articulation and longitudinal coherence, which targets cultural necessity, before organizational, to think and act in terms of circuits and courses of treatment; d) the true and ethical foundation of the logic of the responsibility taken for the patient-problem-need and of continuity of the attention-evaluation is in the recognition that the reference category is that of “human rights”, that is intrinsic to human beings: the needs-diseases, disabilities, lack of auto-sufficiency can be taken seriously (in their specificity and variability, in their expressions of severity-gravity or welfare-level of problem severity dependent) only if there are normally acknowledged as part of citizenship rights which are nonnegotiable.

In this reference frame, psychiatry, which had culturally predicted and institutionally tested some great intuitions of medicine and health research is today at great risk of marginality (cultural, methodological, scientific and organizational – managerial), which can only be avoided by investing in two fundamental theoretical-practical fronts: a) the development of an epidemiology of rights, as permanent operative model of evaluation of practices and services (early intervention, assistance continuity, reduction of disabilities, information, empowerment, struggle against stigma); b) attention to the person in his/her entirety, and not to the systematic aspects, which move away from psychopathological understanding and to the construction of effective treatment relationships.

Along the way problems are assessed connected with the professional identity of the operators. The pursuit of consciousness (or of the sense) of psychiatry today, and of its institutions/praxis, must consider these scenarios and actors in movement, which involve and characterize the complexity and specificity of our discipline in a new way.

In our “yesterday”, the identity of psychiatry (and more generally the mental health operator) was declined around the meeting of three levels: a) humanistic level, focussed on the attention on the person; b) scientific technical level, which constituted the reason for the professional decision; c) ethical level, which looked at the rights of those more weak, met with and known in the simplified frame of the entire institution.

Already in our present, but most of all in our future, the problems are more articulated. Science is on the brink among new challenges (and possible achievements) and old problems, among hypotheses and their transfer to the real world; among facts and stories, which are irreducible of the meeting between human beings. Technical proficiencies move along on various aspects of the area of discipline and are not always possessed (nor possess-able) by every professional. The demand sees the change in needs, problems, diseases, persons, institutions and relationships among them. The social mandate, ultimately, appears, more so today than yesterday, to be a contradictory intertwining between reduction of the delegation to the technical with requirement for more information/participation, and anticipation of a “strong” behavioural science, capable of explaining and managing any event; amid shrinking of the
area of expertise with respect to encoded diseases to amplification of behaviours; among development of services concentrated on rights and the appearance again of responses characterized by institutionalization and control.

These reflections based on our vision of the problems in the field and for certain not free from subjectivity and passion, aim to contribute to opening horizons of thought and of individual and group observation.

“Opening” perspectives and minds is a fundamental process in our field, so we are not reduced to observing the world (the patient, disease and their intertwining) through keyholes, limiting the observation, and the resulting operational choices.

**CONCLUSIONS**

Thirty years from the reform, at what point are we, and what is needed?

At what point we are: closure of the psychiatric hospitals, and beginning of closure of judicial psychiatric hospitals; complete integration of psychiatry and infantile neuropsychiatry of the SSN (Servizio Sanitario Nazionale, National Health Service); change of disciplinary paradigms: complexity of techniques and treatments; new requirements of training (independent) and research.

For the development of these actions a new cultural, social, institutional, clinical, managerial, sustainability is still necessary, founded on several principles: development of the rights of the citizenship; struggle against all forms, old and new, of unnecessary institutionalization; clinical regime and monitoring of processes and outcomes of every treatment; increase in the multidiscipline nature of and multi-professionalism in the work of/for mental health.

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**References**