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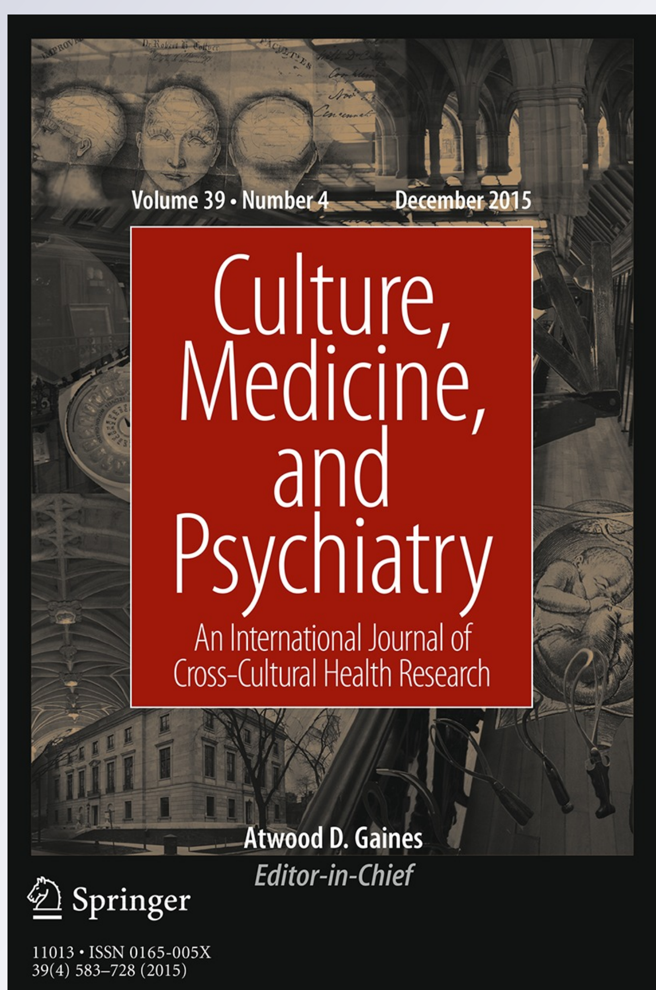



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ORIGINAL PAPER

# A Tale of Two Cities: The Exploration of the Trieste Public Psychiatry Model in San Francisco

**Elena Portacolone[1,2,3] · Steven P. Segal[3] · Roberto Mezzina[4] · Nancy Scheper-Hughes[5] · Robert L. Okin[6]**

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**Abstract** According to the World Health Organization (WHO), the "Trieste model" of public psychiatry is one of the most progressive in the world. It was in Trieste, Italy, in the 1970s that the radical psychiatrist, Franco Basaglia, implemented his vision of anti-institutional, democratic psychiatry. The Trieste model put the suffering person—not his or her disorders—at the center of the health care system. The model, revolutionary in its time, began with the "negation" and "destruction" of the traditional mental asylum ('manicomio'). A novel community mental health system replaced the mental institution. To achieve this, the Trieste model promoted the social inclusion and full citizenship of users of mental health services. Trieste has been a collaborating center of the WHO for four decades with a goal of disseminating its practices across the world. This paper illustrates a recent attempt to determine whether the Trieste model could be translated to the city of San Francisco, California. This process revealed a number of obstacles to such a translation. Our hope is that a review of Basaglia's ideas, along with a discussion of the obstacles to their implementation, will facilitate efforts to foster the social integration of persons with mental disorders across the world.

**Keywords** Anthropology · Mental Health · Basaglia · World Health Organization

✉ Elena Portacolone
Elena.portacolone@ucsf.edu

[1] Institute for Health and Aging, University of California, San Francisco, USA

[2] Institute for the Study of Societal Issues, University of California, Berkeley, USA

[3] Mack Center on Mental Health and Social Conflict, University of California, Berkeley, USA

[4] Trieste Department of Mental Health, Trieste, Italy

[5] Anthropology Department, University of California, Berkeley, USA

[6] Department of Psychiatry, University of California, San Francisco, USA

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## Introduction

"Up close, nobody is normal," 'Da vicino, nessuno e' normale,' reads a popular T-shirt created by the "users of mental health services" in a textile laboratory inside the former psychiatric asylum of Trieste. Nested on the Mediterranean coast, in between Venice and Slovenia, Trieste, an Italian seaport of 235,000 inhabitants, hosts a program of community mental health services called the "Trieste model," which has been recognized by the World Health Organization (WHO) as one of the most progressive in the world (World Health Organization 2001). Started as a pilot in 1974, Trieste is a Lead Collaborating Center of the WHO with a goal of disseminating its practices across the world. The "Trieste model" implements the ideas of Franco Basaglia (1924–1980), a radical Italian psychiatrist deeply committed to the vision that the person with mental illness, not his or her disorder or symptoms, be placed at the center of the mental health system (Scheper-Hughes and Lovell 1986). Basaglia's genius was in discovering that people with even the most severe mental illness could live a "normal" life accommodating their condition in the "community." An essential piece of this model is the creation of "life projects" by users of mental health services in concert with their care providers. These projects foster the engagement of persons with mental disorders in public life through proper housing, job placement, and opportunities to play sport and enjoy art or nature with other members of the community.

The Trieste model is extremely appealing for its original application of Basaglia's illumined vision. Foreign visitors are struck by the elegance of the environments used by users of mental health services, the enthusiasm of care providers, and the breadth of initiatives meant to integrate the persons with mental illness in their community. The visits of the authors to Trieste on different occasions sparked publications (Scheper-Hughes and Lovell 1987; Segal 1989), interactive conference and classroom exchanges in both countries, as well as a series of seminars in San Francisco Bay Area. The first 3-day-long seminar in 2005 centered on the visit of Dell'Acqua, a student of Basaglia and the director at the time of the Trieste Mental Health Department. The event generated so much interest that Dell'Acqua and Okin, the then chief of psychiatry of the San Francisco General Hospital, signed in 2006 an agreement of collaboration between the departments of Mental Health in Trieste and of Psychiatry at the San Francisco General Hospital, an institution affiliated with the University of California in San Francisco (UCSF). Over the ensuing 5 years, Mezzina, the new director of the Trieste Mental Health Department, closely collaborated with Okin and the other authors to determine what would be necessary to apply some of the principles, implement some of the programs, or "translate" the Italian model into the San Francisco system. The intention was to use this exploration to understand the obstacles and to conceptualize enabling mechanisms for the implementation of the Trieste model. In the end, it was concluded that the model could not be translated to San Francisco for a number of reasons discussed in this article. Our hope is that this experience can be useful to others as they consider initiatives to promote the genuine social

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integration of users of mental health services in other parts of the world. The description of the mental health systems in the two cities will frame the discussion.

## The Trieste Mental Health System

Starting in the 1960s, first in Gorizia and then in Trieste, Basaglia and his collaborators, mostly psychiatrists, and other care providers who endorsed his vision, challenged the prevailing medical, social, and legal justifications for the segregation of persons with mental illness. Basaglia, once an academic scholar who wrote dozens of dense essays on psychiatric phenomenology, technical scientific essays on neurology, and dabbled in experimental psychology (Basaglia and Basaglia Ongaro 1975, 1981, 2005), walked away from the ivory tower of academia, rooted in the asylum, and abandoned the medical scientific model of psychiatry to walk the streets of Trieste and to enter into the everyday lived world of the suffering.

Basaglia and his team refused to view even the most severe forms of mental illness as permanently incapacitating, as social deviance, or as a "dangerous" threat to "normal" people, as was common at the times. In radical contrast to these views, what came to be known as "The Trieste Model" promoted social inclusion and all forms of economic, political, and social opportunities for individuals with mental illness (Dell'Acqua and Cogliati Dezza 1985; Rosen, O'Halloran, Mezzina 2012). The successful phasing out of the mental hospital in Trieste led to the transfer of resources and services in the new community system of care (Rosen et al. 2012). This process culminated in the passage of Law 180 in Italy in 1978, the innovative legislation that led to the final closure of all asylums in Italy. Law 180, which mandated the creation and public funding of community-based therapeutic alternatives and affordable living arrangements, sought to restore the human, civil, and social rights of users of mental health services. The restoration of citizenship in its broadest sense—the right to live in and participate in the social life of the community, the right to housing, to form social cooperatives, to participate in unions, political parties, religious, and civil organizations, the right to be mentally different—was central to the process of deinstitutionalization in Trieste. The fulcrum of the restoration is the creation of a "life project" through the dialogue between service providers and the users of mental health services. Life projects are developed to infuse structure and to inspire meaning to the lives of those who seek mental health services. Through this project, therapist and user imagine the unfolding of relationships and resources over the course of the entire person's life. The focus on life projects raises the stakes as the psychiatrist and the entire care team shifts its attention from the symptoms and emphasis on bare survival to the long-term social integration of the individual. Providers enter a shared struggle with those suffering from severe mental health problems to fight the common existential experiences described as a void of daily life, as well as to restore or to build anew a network of social ties and support. The role of providers is to work side by side with the users who are seeking to change their subjective position of users from a state of passive dependence to one of active and engaged participation. In other words, the

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life project enables the shift from managed exclusion to a true social inclusion, at least to the degree that users become individuals with the same rights and standing of other citizens. An essential ingredient to the success of the life project is the availability of resources such as affordable housing and health care services, as well as employment. The search for opportunities for recovery and social inclusion performed by the user in concert with the care team complements this approach.

Today, in Trieste, the Department of Mental Health that evolved from Basaglia's vision operates through 207 mental health workers, including 22 psychiatrists, 127 nurses, and 58 among psychologists, social workers, psychosocial rehabilitation specialists, and nursing aids. Providers operate in a small general hospital psychiatric unit, a rehabilitation and residential support service, and four community mental health centers. In 2012, they served more than 4000 users of these services. Most mental heath services in Trieste are provided through four community mental health centers, each covering a catchment area of 60,000 residents. Open 24 h every day, weekend and holidays included, each center has an average of six beds. On average, each of the four community centers provides inpatient and outpatient services for more than one thousand people per year. Persons in crisis or with acute psychiatric conditions sleep in their facilities rather than in the hospital (Mezzina 2014). As soon as their condition improves, they receive day care at home or in a community center. Started with the aim of reducing psychiatric hospital admissions and promoting rehabilitation and social integration, the community centers constitute the core of mental health services (Mezzina and Vidoni 1995). The community mental health centers epitomize the philosophy of the Basaglian deinstitutionalization through their design, locations, and services.

To elevate the status of the persons with mental illnesses in the community, aesthetic, comfortable well-lit, and tastefully furnished spaces were created. This has also the effect of nurturing a sense of self-worth and is meant to eliminate barriers between these spaces and the external world, as well as to eliminate the bleak look of many psychiatric institutions and even many community services. For instance, the "Barcola Mental Health Center" that Mezzina directed for decades is located in an elegant villa surrounded by a manicured garden facing the Adriatic Sea. Outside, its walls are painted in a bright yellow, and a rectangle of rosemary, lavender, and big pink daisies shields the front entrance veranda. Nearby trails leading to the beach or to a pinewoods park are often the backdrop of dialogs between providers and users. Inside, the first floor has a reception, an office, a pharmacy, and a large meeting room. The interior designer hired to create a social habitat employed colors, shapes, and a wooden floor to lighten the center. For instance, in the meeting room, a series of postcard-sized squared pictures of flowers are aligned on two white walls; wooden cream and azure chairs surround a white rectangular table. Sets against the wall are two wooden chairs with an extended seat so that they can accommodate three people. Sunlight enters in the community room where an interdisciplinary team meets every day to discuss the cases of persons followed by the center.

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Community centers like Barcola are supported by the general hospital psychiatric unit that provides inpatient mental health services. Its six beds are mainly used as a filter for night emergencies, and it usually releases patients within 24 h, often referring them to their local community mental health center. Centers are also supported by staff of the rehabilitation and residential support service. Located in the former institution, the center manages 45 beds in group homes operated mostly by NGOs through personal budgets for the users. The aim of this service is to encourage users to move from living together toward independent or less supported housing schemes. Social workers, in coordination with providers in the rehabilitation and residential support service, help those in need of services in their search for a home. Once the home is found, sometimes the mental health providers organize a house-warming party with the help of neighbors to welcome the new residents to their community. Integration is also facilitated by various initiatives that encourage persons with mental illnesses to participate in community events such as soccer tournaments, literary and philosophical circles, music bands, and theatrical productions. Another important component of the Trieste model is the professional training in the form of on-the-job training, often with the participation and contribution of service users. The Trieste Mental Health Department pioneered these activities with the assistance of community members. The Department, which has control over the mental health system, led the development of initiatives aimed at integrating the psychiatric users into the social fabric and thus promoting their recovery.

The Trieste Mental Health Department also facilitated the creation of settings where users of psychiatric services manage small businesses following the social cooperative framework. Within this framework, workers participate in the decisions related to their business. In Italy, tax exemptions are provided for employees hired from disadvantaged members such as users of mental health services, as well as persons that were addicted to drugs, disabled, former prisoners, or youth at risk. In Trieste, the first cooperative was set up in 1973 by users supported by providers for cleaning the mental hospital where users resided. Despite an initial resistance from the administration, users of mental health services did join a cleaning cooperative and began working for the same hospital in which they were interned, under union rules and salaries. They were no longer inmates, but workers with salaries and rights. Today, the Tritone Hotel is a residence overlooking the sea entirely managed by a social cooperative mostly composed by users of services of the Trieste Mental Health Department. ‘Il Posto delle Fragole’ (Strawberry Fields Café) is a busy restaurant managed by users of mental health services. In Trieste, the cafés at the opera house, the public radio station, a historical bathhouse, all museums, public gardens, by contract with the social cooperatives employ at least one-third—generally more—of the mental health service users.

The allocation of funds by the Trieste Mental Health Department reflects the commitment to provide services in the community. In 2012, 20 % of the 18 million euros (approximately 25 million U.S. dollars) spent by the department were payments to service users, in the form of job grants and economic subsidies, as well as payments for group activities, trips, and personalized health care budgets, for an average of four million euros. On average, every year 180 people receive

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professional training supported by work grants, with 13 % moving into non-subsidized jobs each year. Also, approximately 160 clients every year receive a personal health care budget to cover support services for their "life projects" including housing, work, and the building of relationships. Only 6 % of the overall budget in 2012 was spent on in-patient services and 6 % on pharmaceuticals. The remaining funds financed community-based services.

It is useful to place the reform of Trieste's mental health system into the context of what occurred in the rest of Italy. Basaglia was able to exploit the accomplishments in Trieste as a way of formulating and gaining approval for Law 180 in 1978. His success partially stemmed from the sudden receptivity of the political establishment that felt threatened by the "Radical party." The latter were preparing to promote a national referendum that would have abolished the current law based on asylums, but without creating a community mental health system to replace them. Through Law 180, Basaglia's intention was to create an extensive system of community mental health centers in the regions supported by a limited number of beds for crisis care in local general hospitals. Well aware that the Trieste model, such as other avant-garde experiences (Arezzo, Perugia) was attained as a result of a very committed team, a circumscribed and favorable political environment, and certain auspicious demographic factors, Basaglia sought through Law 180 to replace mental hospitals with a community-based system.

The process of reforming Trieste's mental health system and enacting Law 180 was relatively smooth in that city, but the process of disseminating the reform in the rest of Italy was hindered by a number of factors, including Basaglia's sudden death 2 years later. First, lacking a national budget to implement the law, each of the 21 Italian regions was often faced with the difficult challenge of executing the law without the money necessary to do so. Moreover, it was a full 15 years after the enactment of Law 180 that a national plan of mental health was developed to guide the implementation of the Law. This plan was authored by Basaglia's widow and former students. Second, care providers throughout many parts of Italy often felt uncomfortable in providing services outside the institution, which delayed both the implementation of the Law and the promulgation of supporting legislation in many regions.

The results of these obstacles can be seen in certain parts of Italy today. Some regions continue to have weak and unfocused community-based services and fail to provide adequate crisis care or long-term supportive services. Moreover, most community mental health centers are open only 8 h a day, 5 or 6 days a week, and rarely offer 24/7 service, or the kind of comprehensive, life-centered care available in Trieste. Trieste and the region of Friuli Venezia Giulia continue to provide the most progressive services in the country and follow users for their whole lives (Mezzina 2014).

Notwithstanding this evidence for an incomplete implementation of Basaglia's vision, the overall results of the Italian reform initiatives have been dramatic. By 1999 all mental hospitals were closed. Community mental health centers under the authority of regional Mental Health Departments were created in each region at a ratio of one center for a population of 80,000. Fifteen bed inpatient units in general hospitals (one bed every 10,000 residents) currently operate in most parts of the

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country along with day centers and 19,000 sheltered community residential beds in small group homes, more than in any other country in Europe (Mezzina 2014). In the area of employment, there are over 4500 social cooperatives, each of which employs both disabled (30 %) and non-disabled people. These are supported by government tax incentives. Finally, the number of involuntary commitments throughout the mental health system has fallen dramatically and is the lowest in all Europe (Rosen et al. 2012). Notably, this has been accomplished without an increase in the suicide rate, without a significant increase in homelessness, and without trans-institutionalization to jails, prisons, or forensic hospital sector, all of which had been wrongly predicted by the Law's critics.

## The San Francisco Mental Health System

San Francisco is a relatively small, compact city with a population of 850,000 with stark disparities in the income of its residents. In the last 6 years, San Francisco surpassed New York as the U.S. city with the highest income gap between rich and poor residents, and the number of very poor and disadvantaged people is very large. This creates a situation in which the demand for human services is intense and competitive. In San Francisco, the intersection of a strong market economy and a retrenched welfare state led to two types of care for persons with mental disorders. According to the American Community survey, approximately 39,000 San Franciscans had a mental disorder in 2006. While affluent residents with mental disorders can afford private premium services that integrate them into their communities, the majority of those with meager resources cannot access these services and rely on the public mental health system. This system consists of a patchwork quilt of community-based services operated by many non-profit agencies. Because of the rash way in which deinstitutionalization was implemented in California and because of the relatively high migration of mentally ill people to the city, San Francisco is home to a very large number of people with severe mental illness. As in other parts of the U.S., the social safety net on which these people depend is thin, and their economic rights are very limited. In contrast to Italy, in San Francisco there is no right to housing, a very restricted right to health care, and a system of welfare payments that are so low as to keep people who depend on them in abject poverty. Compounding this is the fact that the family structure in the U.S. is much looser than that of Italy with much greater geographic dispersion of family members. Many people with mental and physical disorders, as a result, cannot rely on their families for support. This situation is further aggravated by the fact that housing prices in San Francisco are exorbitant and only a very limited stock of decent affordable housing exists (Erwert 2014). Even the middle class struggle to pay rent. San Francisco has one of the tightest housing markets in the country and no effective mental health service for people with severe mental illness has been successful without the provision of adequate housing. In addition, as in many poor and complex urban areas, the incidence of neglect is high, which creates a feeder system for certain kinds of mentally disabled adults. Finally, drugs are readily available and drug abuse is rampant, especially in the poorer areas of the city.

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The San Francisco Department of Mental Health oversights the system of mental health care and provides the majority of its 212 million dollar funding. In proportion to the population, this budget is much greater than that of Italy; however, the populations served in the two cities are very different, as are the local political, economic, and social systems. The San Francisco mental health system comprises 21 acute involuntary inpatient beds and 42 locked sub-acute beds in the San Francisco General Hospital, 80 additional acute beds in non-profit hospitals, 250 sub-acute beds in several locked facilities outside the city, and an array of community mental health services, some operated by San Francisco Department of Public Health, others by nonprofits. The local community mental health services consist of outpatient clinics, case management services, crisis intervention programs, and over 3000 supported housing units for previously homeless people. In addition, one 24 hour supervised crisis intervention home provides emergency residential treatment to acutely ill patients who do not require hospitalization, and several group homes and cooperative apartments provide longer term residential treatment.

The UCSF-affiliated department of psychiatry at San Francisco General Hospital is a major provider of community mental health services. In addition to its inpatient services, the department operates the city's psychiatric emergency service, eight assertive community treatment programs, and other individual intensive case management services for thousands of patients at risk of psychiatric hospitalization, as well as for repeated users of inpatient treatment, high users of the criminal justice system, and high users of the medical emergency room (Okin et al. 2000). The department also operates a Trauma Recovery Center for victims of violence who are showing symptoms of emotional problems (Boccellari et al. 2007). Through their personal clinical relationships with clients, the case managers in each of these programs give their clients intensive, often daily support which they need to survive in the community. In addition, they help their clients get access to housing and public medical and welfare benefits.

Notwithstanding this array of services, the public mental health system has not been able to keep pace with the demand. Beginning in the 1970s, a large number of mentally ill people were discharged from state mental hospitals in California, all of which were closed or converted to forensic hospitals to house the severely mentally ill prison population. Because resources generally did not follow patients from the mental hospitals into the community, many formerly hospitalized patients ended up in San Francisco without services. Many others came to the city from other parts of the country, attracted by the mild weather and liberal politics of the city. The combination of a very large number of mentally ill people, the lack of affordable housing, the drug epidemic, the thinness of the social safety net, the dearth of affordable housing, and the relatively loose family structure has led to a virtual abandonment of many mentally ill people in the city. Despite the fact that many are cared for and supported by excellent state-of-the art case management programs, many others are treated by overwhelmed staff who can barely work to control their acute and chronic symptoms, much less help them develop life projects, attend to their social needs, or help integrate them into the life of the community. Because adequate health, welfare, and housing services are not provided through the public

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human service system, the mental health system must pick up some of the slack through its own limited budget. Patients are consequently limited in what mental health services they can expect and often have to wait years for housing with on-site treatment and support. Others, cut off from their families, are forced to live alone in poor, dilapidated Single Room Occupancy Hotels with minimal supervision, where they barely survive in small, cramped rooms without a private kitchen and bathroom. They survive on Supplemental Security Income, a public subsidy that barely covers the cost of their rooms. Because of the paucity of vocational and social programs their lives are empty. They have little to do during the day except hang out in their rooms or on the street, often assuaging their symptoms and counteracting boredom through resorting to hard drugs. While a handful of people are occupied in supported work and other life projects, the overwhelming majority are not.

A cursory examination of streets and jails shows the abandonment of these people. There are 6000 homeless people in this relatively small city of which over 2000 are mentally ill, most having substance abuse disorders as well (Sullivan, Burnam, and Koege 2000). Many other mentally ill people are incarcerated in jails and prisons, facilities that have largely replaced mental hospitals as institutions fulfilling society's determination to segregate and hide from view these stigmatized people. An estimated 25 % or 13,000 San Franciscan jail inmates have a psychotic disorder based on DSM IV (James and Glaze 2006).

It needs to be emphasized that this situation exists in San Francisco despite the many successful, if inadequate, efforts at reform that have taken place in the U.S. over the past 50 years, most of which have prevented the situation from being worse than it is. These reforms, though often overlapping with those of Trieste, have a lineage that is independent of Basaglia and the Italian experiment, and have their own American wellsprings. In 1948, 30 years before Law 180 was passed in Italy, Fountain House, the first Clubhouse model of care, was opened in New York. This model, which centers on supportive vocational services, socialization, "member" empowerment, and inclusion in the life of the community now serves 100,000 people and has been replicated in many other countries. In 1963, under President Kennedy, the Community Mental Health Centers Act (Mechanic 1990) was enacted which represented the first time that the federal government substantially assumed some responsibility for people with mental illness, responsibility that had historically been held by the states. Since then, mental health services were included in the general health legislation of MediCaid[1] and MediCare[2] in 1966 (Mechanic 1990). Supplemental Security Income was broadened to encompass welfare payments to substantially and permanently disabled mentally ill people (Daly and Burkhauser 2003). In 1990, the Americans with Disability Act was passed in Congress, which prohibited discrimination on the basis of disability, and the Mental Health Parity Act was enacted which required health insurance companies to provide insurance for certain mental health conditions on a par with physical conditions. As it became apparent just how many mentally ill people needed

[1] Medicaid is the public health insurance system for indigent persons in the U.S.

[2] Medicare is the public health insurance system for adults 65 years of age and older in the U.S.

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housing assistance, the federal government began to fund a variety of housing initiatives, which have now culminated in the provision of a Shelter-Plus-Care policy, enabling people to gain supported housing placements with opportunities for help in living more productive lives. In parallel with these federal executive and legislative reforms, the Supreme Court handed down a number of decisions restricting the use of involuntary medication and involuntary commitment and asserting a limited statutory right to community services under certain conditions. It must be said that these decisions, along with state legislation, though by and large positive, had the paradoxical effect in many cases of exchanging peoples' freedom from involuntary hospital care to involuntary incarceration and leaving many in need of protection of their health and safety on the streets to "die with their rights on."

Meanwhile, at the local level, experiments in the provision of services were occurring that had important effects on the ways that people with serious mental illness were being treated. Group homes (Okin 1983), Assertive Community Treatment Teams (Stein and Test 1980), Clubhouses (Sweet 1999), transitional employment services (Drake et al. 1996), integrated treatment such as the Village in Long Beach (Chandler et al. 1997), consumer-directed and -operated programs and other services of the consumer and survivor movements (Athena 2010; Tomes 2006), all had a major impact on the treatment landscape across America. An emphasis on person-centered care, rehabilitation and recovery, community integration, and experiments in the closure of state hospitals (Okin 1995) similar to Trieste's initiatives in many places supplanted the emphasis on mere symptom control. Underlying this emphasis was the conviction that mental illness could not exclusively be conceptualized in biological terms, but was highly influenced by the social circumstances in which they developed, ideas that were very prominent in Basaglia's writing as well. Anti-stigma community education efforts, which were a required service of the CMHC Act of 1963, have continued to be funded, though very modestly, at national, state and local level. These have their parallels in Basaglia's original initiatives in educating the city of Trieste about mentally ill people using patient-operated radio programs, articles in the press, and public events.

## Structural Differences Between Trieste and San Francisco

Major historical and structural differences exist between Trieste and San Francisco that largely explain the difficulties the latter has had in implementing successful reform. Compared to San Francisco, Trieste is a middle class, homogeneous city with strong community support networks, very limited drug abuse, and no homelessness. There are, as a result, a relatively small number of people who need human services and an even smaller number who need mental health services. People with severe mental illness who are homelessness, as well as addicted to drugs, poor, and without family support practically do not exist in Trieste. Also, Trieste has a declining population and a surplus of affordable housing that enables its mental health services to accommodate their clients in affordable and dignified

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apartments, and without a draw on its mental health budget. Housing is considered a right of citizenship supported by the government. Moreover, Trieste exists in a country with a strong family structure, a relative lack of geographic dispersion among family members, and a strong sense family responsibility. A crucial function of the Italian government is to protect the social and economic rights of its citizens. Italians have a right to health care, housing, support for families, and a concept of subsistence. Finally, the history of Trieste's mental health reforms, including the fundamental challenge to institutional values and the grass roots political support that the mentally ill garnered from other disadvantaged groups have all influenced the shape of the resulting community mental health system. The movement—at least in the 1970s—was supported in the political arena by a broad spectrum of allies among social movements for workers, women, and students whose social critiques overlapped with the critique of the mental asylum and a recognition of the mentally ill as the most disadvantaged and oppressed class in society (Scheper-Hughes and Lovell 1986). This strong alliance supported innovative services for mentally ill people, condemned their abandonment, and gave tremendous impetus to the social aspirations of the deinstitutionalization movement, including the full social integration of the mentally ill and the restoration of their citizenship and their buried human capacities. The widespread support among civil rights and labor rights groups in Trieste for the social integration of the mentally ill prevented the traditional medical establishment from toppling the movement as wildly romantic, impractical, and political sentiments that were widespread among traditional psychiatrists.

This context is extremely different from San Francisco, a city with wide economic disparities, a large class of people who are extremely poor and thus depend heavily on the government for services, a lack of affordable housing, substantial numbers of homeless people, an ongoing drug epidemic, and a lack of economic opportunities for very poor people, much less disabled poor people. In contrast to Trieste, San Francisco exists within a neoliberal nation that values freedom, individual autonomy, and civil rights over economic and social rights, including the right of mentally ill people to be a real part of society. There is limited mental health funding and much of what exists occurs through a medical reimbursement system that is severely capped and does not fund many of the interventions needed by mentally disabled people including jobs, and life projects. The biological model which underlies this fee-for-service reimbursement system requires that services be "medically necessary" as the condition of funding, rather than also "socially necessary."

Although deinstitutionalization first began 50 years ago, San Francisco, like many places in the U.S., has not been able to escape the way it was implemented (Segal and Jacobs 2013). Throughout most of the deinstitutionalization movement, people with mental illness had few political allies and were never adopted by either of the mainstream political parties or by advocacy groups that shared their marginalized status. In contrast to Trieste, the political forces interested in cost containment predominated over those invested in improving patients' lives. Most of the funds from the declining hospital system were reabsorbed by the state budget

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rather than being used to finance a community system (Segal 1979). The community system was thus starved of resources at the outset.

Moreover, the political philosophy underlying the deinstitutionalization movement in the U.S. was not as radical as in Trieste. The American emphasis on liberty in the context of social and economic abandonment led to the dumping of patients from mental hospitals into the streets. Both a cause and an effect of the impoverishment of the community system, providers in San Francisco were forced to focus most of their attention on clients' bare survival rather than on the promotion of citizenship, inclusion, and life projects. Consistent with this, the historical lack of economic opportunities in San Francisco for very poor people, with no government support available to businesses that hired mentally ill people, insured that the latter would be deprived of resources, a reasonable social status and the self esteem that comes from working, and would remain dependent on a government welfare system that kept them in abject poverty. Since there was never any fundamental challenge to the hierarchical power relations including the role of clinicians as "experts" that suppressed patients in institutions, the "new" services that were developed in the community often perpetuated the authoritarian values that characterized and supported the "old" mental hospital. These values were frequently antagonistic to a more egalitarian relationship between providers and clients and made it more difficult to help the latter flourish in society. As San Francisco demonstrates, the reforms in the U.S. that have taken place over the years since deinstitutionalization has not gone far enough, have not been funded enough, and in many cases have only created islands of excellence, whose generalization has been hampered by funding limitations, by demographic problems, and by a thin social safety net.

In summary, the development of community services in the United States by and large took place in a sociopolitical and demographic context that was much less hospitable to reform than in Trieste. Moreover, in contrast to Trieste, the challenge to institutional values was less radical in the U.S., the anti-stigma efforts on which social inclusion depended were less extensive, and the health care system was saddled with a medically oriented form of reimbursement that did not pay for certain crucial services that mentally people needed to thrive in society. Further the process of deinstitutionalization was much less focused on what persons with mental disorders needed (certain kinds of community services), rather than on what they did not need (the institution), as the term deinstitutionalization so aptly conveys. Finally, in many places in the United States, the administrative authority for implementation of reform was fragmented between different levels of government, and among different agencies within each level. In Trieste, implementation occurred under the authority of a single administrative entity.

## Different Approaches

The exploration of the translation of the Trieste model in San Francisco also stimulated a rich dialog among the authors of this paper as they grappled with the structural differences between the two cities. While all authors agreed that a wholesale translation of the Trieste model to San Francisco was unconceivable

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given the above structural differences, questions emerged on the practical application of Basaglian ideals and on the efficacy of initiating ad hoc micro-initiatives. A report created by Mezzina (2007) after his one-week visit of the San Francisco's public mental health system started the discussions. It is important to share the report, as well as the questions it generates, as these ideas can inspire initiatives meant to increase the social integration of users of mental health services.

As a starting point, Mezzina suggested the consideration and review of the San Francisco General Hospital, as well as any services for the mentally ill. This review, he suggested, should include the inspection of the services provided, their vision, as well as of the relationships between staff and patients, the staff's attitudes, the psychiatrists' perspective and assumptions, and the overall social function of the "institution." This review should begin at the user's level. For example, with regard to the homeless, Mezzina suggested that the providers of services place themselves in the users' place and perspective. Care providers should reconstruct and analyze what normally happens when a San Franciscan presents with the first psychiatric problems, at what point in time either the service arrives, or the person arrives at the service. Once the person connects to the services, providers should study what happens within the service in terms of pathways of care, procedures, protocols, practices, as well as ways out of the circuit. To facilitate the empowerment of users of mental health services, all the care providers who serve these persons must feel empowered as well. Within this frame, the gap between psychiatrists and other professionals such as nurses and social workers should decrease. The continuity of care should be a priority of the entire mental health care team. As a result, the therapist and the mental health team should follow the users of services as they leave the hospital and move into the community. This implies a consistent transfer of resources, particularly staff, to services based in the community. On a related note, care providers should consider the person as a person and not simply as a patient, and thereby become responsible not only for the mental illness but the overall integration of the individual in his or her community. In this case, the attention expands from the illness to the person and their life as a whole. This essential paradigm shift initiated by Basaglia 40 years ago requires that mental health care providers become the 'missing link' that connects the person to essential social and community services, following up on them and making sure that the connection is maintained, and solving any issues that may arise in the process. This requires a new roadmap for mental health service workers who are contained within a paradigm that is overly bio-medical and clinical, focused on the diagnosis, the illness and behavioral problems, as if these encompassed the entire history and needs of the person with mental disorders.

The first question raised by this first set of recommendations is How is it possible to implement these changes within the constraints of a system that pays providers for specific bio-medical interventions rather than for recovery and social inclusion? In other words, how is it possible for providers to expand their role and the mission of their service when they are already overcommitted and their salaries tightly tied to specific actions that exclude their service seekers' lives in the broader context: housing, meaningful work, meaningful relationships, space for creativity, love, and recreation? In addition, how is it possible for providers to provide a continuity of

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care given the scarcity of resources available for low-income users and given the elevated degree of co-morbidity of these individuals, who are also often drug-addicted, homeless, recently released from jail or from prisons where they have been subject to institutionalized human rights abuses and consequently often lacking or deprived of any informal support system?

What is the value of reviewing personnel roles when the time and the space needed for change is not supported by the limited requirements and salaries of the mental health service workers? First and foremost, the rules need to be changed and that is a huge and largely political undertaking. For example, a capitation model in which a set amount of money is provided for each enrolled person assigned to the care workers per period of time, rather than the existing fee-for-service model would give more leeway to providers to move beyond their traditional roles. However, changing the pay model would not solve the shortages in personnel, in community mental health services, rehabilitation, or safety net services. Moreover, in other areas of the U.S. where a capitation model has been used, it has often led to a neglect of persons with severe mental illness. This occurs because the model has incentivized providers to deliver the least amount of care they can get away with, as the lesser the services provided, the larger the profit margin.

The next set of questions challenges the value of initiating changes at the microlevel with the hope of breaking new ground at the macro-structural level. These structural questions are inspired by the work of Basaglia as he sought the endorsement of the political sphere to implement his vision on a long-term basis. The questions can be summarized as Is it really enough to beautify the environments provided for users of mental health services? For example, Mezzina's recommendation was to find resources to upgrade a single occupancy room facility (a so-called "hotel") occupied by users of mental health services and to have the upgrade done mostly by the new residents themselves. Questions arose about the amount of work required to renovate a hotel, the cost, and the extent of these upgrades. One, helping the future residents do the upgrade would take considerable time from care providers, unless these providers were willing to volunteer some hours each week to this end. Two, while temporary resources—grants from foundations or nonprofits for example—would likely fund and manage this original initiative, it is less clear though for how long these resources would be available on the long term. Creating and sustaining beautiful, dignified, and safe housing would have to be a long-term continuing revolution, to invoke the language of Franco Basaglia.

With the role of the state retreating, the overlapping initiatives of non-profits usually have a short reach because of the limited and temporary resources available to them. Even initiatives on a larger scale and funded by the state have limited long-term funding. For example, the Affordable Care Act signed by President Obama in 2010 allows states design "Health Homes" to provide comprehensive care coordination for Medicaid beneficiaries with chronic conditions. The underlining principle is that residents of these homes receive primary, acute, behavioral health, and long-term services and supports to treat the whole person. In line with the Basaglian vision, the state website states "CMS [Centers for Medicaid and Medicare Services] expects states health home providers to operate under a 'whole-person' philosophy" (Medicaid.Gov 2015). However, when we look at the source of

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funding of this innovative initiative, we learn that federal funding will last for only the first 2 years of the project, and then the providers need to obtain resources in other unspecified ways. Overall, the obstacles to secure financial support for long periods of time challenges isolated initiatives such as the renovation of a hotel. A lesson from this experience is that unless government creates a stable source of funding, it is rather risky to develop long-term projects publicly endorsed in the first 2 years of their life.

A third set of recommendations revolved around the Basaglian therapeutic model of "life project." According to Mezzina, care providers should forge a "therapeutic alliance" with the users of mental health services and envision practical steps that will lead to the social integration of the user of mental health services. Questions that arise from these ideas are once again related to the feasibility of making this shift given the scattered and limited amount of resources available to low-income users and the fact that the weak to nonexistent safety net for poor people in general creates a vacuum which is under current conditions all but impossible to fill.

Finally, the last set of Mezzina's recommendations focused on the creation of events that would provide opportunities for synergies between users of mental health services and their community. With Basaglia, recruiting well-known artists such as Ornette Coleman and Nobel Prize awardee Dario Fo perform at events organized and hosted by the mental health department and attended, as well as organized by, those using mental health services helped dismantle the stigma associated to mental illness. Related initiatives involved acclaimed poets, philosophers, and theater directors collaborating in plays performed by users of mental health services at major local theatres. The media can also educate the public on the importance and challenges of integration. For example, acclaimed movies such as *The Best of Youth* showed the abusive conditions of a group of mentally ill who were forced to live in a basement and their liberation by the efforts of psychiatrists following the Basaglian model. Recently, an Italian television series dedicated to Basaglia appeared in prime time on the national television channel. Here is one instance where the strong and resilient arts and film and performance history and culture of California could be recruited to establish grants and events such as a summer film festival of the absurd, that might create a space to recognize the madness that is inside all of us. California is the birthplace of many famous music and film festivals, including the Dickens Fair, the Jewish film festival, and the Renaissance Faire in addition to radical projects like the Burning Man festival in Nevada. The Basaglia movement was enhanced enormously by music and film and by the radical Italian film collective, inspired by Basaglia, that produced award-winning films including *Madness My Love* and *Blue Planet*.

## Conclusion

The demographic differences between Trieste and San Francisco, along with the structural problems of the latter, the drug epidemic, the thinness of the social safety net, along with other factors made it impossible for the authors to envision translating the Trieste model to San Francisco. Although San Francisco hosts many

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excellent services with radical aims that have improved the lives of thousands, its experience demonstrates that the efforts at reform in the U.S. over the last 50 years, though significant could not alter enough the crucial structural obstacles to fundamentally transform the experience of people with mental disorders. They may have less symptoms, but most are still living in poverty, deprived of meaning and aspirations. A mental health model of care, no matter how progressive, cannot be fully implemented in the absence of a hospitable context in which to embed it. In fact, this is one of the reasons that the Basaglia's model has not been fully implemented in the rest of Italy beyond Trieste. Despite the robustness of the social safety net, and other elements conducive to reform, other factors crucial to its translation have not been fully present there.

Notwithstanding the profound differences between the two cities, the Trieste model has much to teach us and can serve as an important source of inspiration and validation of some of the American experiments whose lineage was different. It reminds us that any progressive mental health system must be based on a belief that mentally ill people are first and foremost human beings with social and economic rights, not just civil and political rights; that they have a right to flourish, not simply be free of overt forms of coercion; that their problems in many cases are not simply biological, but are aggravated by the society in which they live; and that providers are responsible for addressing the totality of their needs, not just their symptoms. The Trieste model is inspiring precisely because it demonstrates what people with mental illness are capable of when they are helped to lay claim to their economic, social, political, and civil rights, and are given access to mental health services that include a vision of mental health as part of life itself.

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