The formation of deinstitutionalization discourses in Italy and England: a cross-national archaeological study

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ABSTRACT

This thesis offers new insights into deinstitutionalization and a fresh perspective on international differences in mental health care systems. Deinstitutionalization is a term used to describe a major transformation in the provision of psychiatric care (Bachrach, 1976), the move away from care delivery exclusively in long-stay psychiatric hospitals and towards the creation of community-based services. Although such shifts have been acknowledged as an international trend (Goldman et al., 1982), mental health care scenarios are characterized by high levels of differentiation. The rationale for this study was that these differences required more careful consideration.

The thesis challenges the widely held assumption that deinstitutionalization is an international trend. It presents a cross-national archaeology of the emergence of the deinstitutionalization discourses in Italy and in England. Legal and psychiatric documents produced in the two countries are analysed as evidence of the national conditions that allowed the acceptance of this shift in the two countries. The findings drawn from the analysis show multiple ruptures and different strategies at the core of the national discourses and practices. In summary, in the English case the emergence of deinstitutionalization was strictly related to a government driven process of rationalization, whilst in the Italian case deinstitutionalization was the result of a strategy aimed at the demolition of the system established during the Fascist period. The thesis illustrates how these differences led to the emergence of heterogeneous psychiatric and legal practices in the two countries. The most striking of these is the complete abolishment of the psychiatric hospitals in Italy. Through the comparison of, and the analysis of the differences between, how the English and Italian deinstitutionalization discourses and practices emerged, this study challenges what is often taken for granted, for instance the notion of the role of the introduction of drugs in the acceptance of treating psychiatric patients in the community or the idea of anti-psychiatry as an international movement.

Key words: deinstitutionalization; discourse; archaeology; Foucault; cross-national

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Following Foucault's insight, I am aware that a document is never just a text, but it is an event. This thesis is an event, not just because is the realization of a dream but because it was the product of a journey that made me meet people, acquire new skills and make new memories. Looking at each line, I can think to, and thank someone.

I would like to express my gratitude to my supervisors, Kate and Matthias, who have believed in my project since the very beginning. Even before I knew what shape this research would have taken.

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CHAPTER I: INTRODUCTION

This thesis examines the historical formation of deinstitutionalization discourses, and related practices, in Italy and England, drawing on an analysis of legal, psychiatric and policy documents. Deinstitutionalization is a term commonly used to describe a major transformation in psychiatric care that allowed "the mass exodus of mentally ill persons from living in hospitals to living in the community" (Lamb, 2001, p.3). Up until the middle of the last century, patients affected by mental illness were cured inside psychiatric institutions. There was a strict correlation between the asylum and psychiatric knowledge, and the psychiatrist's function was restricted within hospital walls. The architectural features of these institutions, including their isolation both of patients and geographically, and their organisation based on rigid routines and hierarchy, were considered an integral element of the therapeutic treatment itself. In line with these psychiatric practices, laws concerning the management of mental illness were limited to the admission, discharge and control of the patients affected by mental illness who were treated in the psychiatric hospitals. Yet at a certain historical moment, this institutional arrangement completely changed, and psychiatric hospitals became demonised as places of treatment. This shift did not only impact on psychiatric knowledge and practices, but it also enabled the transformation of policies and laws concerning the care of people affected by mental illness. This thesis looks at that shift.

Today, deinstitutionalization and the treatment of patients affected by mental illness in the community are considered one of the main goals of mental health care

systems by the European Union [EU] and the World Health Organization [WHO] (Anonymous, 2015). Though processes of deinstitutionalization began almost 60 years ago, many studies have noted that is far from being achieved. Indeed, processes of re-institutionalization have been identified worldwide (Falkhouri and Priebe, 2007). To study this phenomenon and outline best practices, experts have built indices and research designs to compare national mental health care services and systems (Salisbury et al., 2016), the status of integration of psychiatric patients in the community (Huxley, 2015), and many other aspects. These studies reveal high levels of differentiation among different countries, but do not shed light on the reasons for these variations (Shorter, 2007). This study contributes to the analysis of these international differences, precisely by investigating the reasons behind differentiations in the Italian and English cases. It is guided by three main research questions:

a) To what extent and how did the national psychiatric and legal discourses on mental illness in England and Italy change in relation to the shift from care in long-stay hospitals to care in the community?

 b) In what respect did the formation of the discourses on psychiatric care in the community vary between Italy and England?

c) To what extent have differences impacted on national practices concerning mental illness?

My interest in the international heterogeneity of psychiatric practices and mental health care systems is fuelled by my experiences as a psychologist working with

patients affected by mental illness for their rehabilitation in the community in Italy and, afterwards, in England. Working in England, I noticed the inconsistencies between the Italian and English translations of specific concepts, such as care in the community and community care, and differences in terms of the acceptance of specific practices, such as the use of psychiatric hospitals and the use of electroconvulsive therapy [ECT]. These differences became even more puzzling when included in the contemporaneous international context. Since the 1950s, there was an attempt by the WHO to promote the introduction of mental health services in the community worldwide (WHO, 1951), and in 2005, the European Commission was invited by the World Health Organization's European Ministerial Conference on Mental Health to promote a comprehensive action for the implementation of mental health policies (Kelly, 2007). Although the European Commission promoted diverse initiatives[1] to support the harmonization of the European mental health policies and to promote deinstitutionalization, mental health policies are still the most heterogeneous among the European countries, and "institution-focused services continue to dominate much of the European mental health landscape and community-based support systems are patchy in availability and quality" (Knapp et al., 2007, pp.3-4).

My original idea was to approach these differences through the lens of community integration as the main goal of rehabilitation (Townley et al. 2009; Wong and Solomon, 2002), focusing in particular on differences in housing services and the psychiatric practices applied to achieve this aim in Italy and England. As I pursued

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[1] In 2005, the green paper "Improving the mental health of the population: Towards a strategy on mental health for the European Union" was published.

my study, it became clear that the origins of these differences were more compelling to explain differentiation. The introduction of concepts like community integration and social inclusion into psychiatric and political discourses emerged as strictly related to the movement of psychiatric care from the hospital to the community. Thus, my attention shifted from the concepts themselves to the formation and acceptance of the discourses that surrounded them.

Deinstitutionalization has already been widely investigated in various disciplines, such as history, sociology, social policy, and psychiatry, and from a variety of different perspectives. Yet insufficient attention has been paid in socio-historical studies to the differences between mental health systems (Shorter, 2007). Cross-national studies usually centre on comparisons between the current state of psychiatric services and mental health care systems (Salisbury et al., 2016), while cross-national historical analyses of mental health care systems (Jones, 1979; Jones and Poletti, 1985) overlook international differences in their attempt to outline a comprehensive explanatory model of deinstitutionalization (Novella, 2008). Moreover, the majority of historical investigations on these matters focus on the American and British contexts (Bachrach, 1976; Jones, 1972; Rose, 1986; Scull, 1984; Turner, 2004). The aim of this study is to address these issues and provide a Cross-European analysis.

The selection of the Italian and the English cases was not just due to my knowledge of the two contexts and languages, despite the fact this was an essential element to the feasibility of the project, but the English and Italian cases were two emblematic cases in the history of the transformation of the psychiatric care systems

worldwide. England was the first country to develop community-based services for psychiatric patients and to start a process of reduction of psychiatric hospitals, while Italy is the only country to have completely abolished any psychiatric hospital. Both countries were selected by the WHO as examples of good practices in the psychiatric care in the community and, as such, they have been also the objects of international comparisons (Jones, 1988; Ramon and Giannichedda, 1991). In the period between the 1980s and 1990s, the Italian case became the subject of various international studies (Bennett, 1985; Jones and Poletti, 1985; Scheper-Hughes and Lovell, 1986; Donnelly, 1992), for Instance, Ramon and Giannichedda (1991) pointed out that "Italy has provided the Western world with a huge psychiatric experiment from which we can all learn" (p.xiv).

Whilst the community mental health care in Trieste is still an example of best practices in offering psychiatric care outside of hospitals (Mezzina, 2014), an international comparative study on the level of integration of people with mental illness in the European countries published by the Economist Intelligence Unit (2014) scored Italy as one of the lowest European countries. England, by contrast, was one of the highest – together with Germany, where psychiatric hospitals are still active. Findings produced by cross-national comparative studies concerning the implementation of the mental health care systems are quite contradictory in this sense. For instance, according to those studies that consider the success of deinstitutionalization looking at psychiatric beds rates and involuntary admissions, Italy has been depicted as one of the Western countries with the most radical approach toward deinstitutionalization (Medeiros et al., 2008), while England, by

contrast, has been criticised because of the process of reinstitutionalization of psychiatric patients (Turner, 2004) and the high rates of compulsory admissions (Weich et al., 2017). However, other studies taking into account diverse variables concerning deinstitutionalization, such as the accessibility to the services in the community or integrated care for people affected by mental illness, pointed out that England offers better services than Italy (The Economist Intelligence Unit, 2014). This is due to a lack of agreement on what deinstitutionalization means and how to define good practices in mental health care (Thornicroft and Bebbington, 1989; Bachrach, 1989; Salisbury et al., 2016). This thesis seeks to avoid these limitations of comparative studies in mental health care by looking at the problem from another perspective. Rather than using pre-established criteria to compare national implementations, it seeks to illustrate how these differences were formed. In doing so, this study challenges the universality of terms such as deinstitutionalization, community care, and mental health. My assumption is that the implementation of different policies and practices in mental health care, in fact, implied different problematizations of concepts such as mental illness, health and services in the community. It follows that this study does not aim to offer a solution to the problems related to the implementation of deinstitutionalization policies, nor to evaluate the effectiveness of one national implementation system over another. Its aim is rather to examine the formation of two national deinstitutionalization discourses in order to re-think this social phenomenon and to return to the point of transformation to consider how certain paths were chosen over others, in Foucault's words to "open up the space of freedom" (Foucault, 2001, p.36). Drawing on a social constructivist approach, this project assumes that

the formation of discourses and practices that enabled the acceptance of deinstitutionalization policies were strictly related to the historical, political, economic and social contexts in which they developed.

When speaking of "discourses", this thesis refers to the specific use that Foucault makes of this term. Foucault (1991b) considers the unity of a discourse as a social construction, but he questions the categorisation of a text in a scientific discourse such as psychiatry, or the inclusion of a book under the same literary trend, such as romanticism. Refusing to accept uncritically the unity of discourses, the archaeological analysis of discourse challenges any pre-established categorisation, but it considers the discourse as an ensemble of individual events (Foucault, 1972).

In this sense, documents are not looked at in relation to their scientific value or in view of the author but each document is explored as an individual occurrence which happened in specific conditions. Discourses are considered as practices, thus, the investigation does not look to unravel the real meaning behind the texts or speeches, but at the specific circumstances that allowed that particular discourse to be accepted over other possible discourses (Foucault, 1972). "Each discourse undergoes constant change as new utterances are added to it" (Foucault, 1991b, p.54), thus, the formation of a discourse is never the product of progress, but it is the result of contingencies. It follows that the focus of the investigation is not the origin of the discourse, but the way it was validated as the best one (Foucault, 1991b). In this sense, this thesis challenges the notion of deinstitutionalization as the most effective policy, or the product of psychiatric progress. The way how the national mental health care systems have been implemented was only one of the

possible ways they could be implemented. The variety of the international context underpins this assumption.

Taking this Foucauldian approach to the discourse of deinstitutionalization, this thesis seeks to move beyond tautologies about deinstitutionalization by retracing the moment when national psychiatric systems based on hospitals were problematized (Foucault, 1972). In this sense, this study challenges the notions, expressed in previous discussions, of deinstitutionalization as an "international fact" (Goldman et al., 1982, p.153) that characterises all western countries (Miller and Rose, 1986; Novella, 2008). Illustrating the emergence and acceptance of the deinstitutionalization discourses in England and in Italy, this thesis shows the relevance of considering the importance of national conditions in the evaluation of international differences in the mental health care systems.

This idea of discourse as an ensemble of heterogeneous events and the rejection of any pre-established unity are strictly related also to the way in which this thesis deals with history. Foucault's approach to history rejects the idea of progress (Foucault, 1991). Rather than seeking to retrace the linear development of the deinstitutionalization discourse as in the history of ideas, the archaeological investigation focuses on its discontinuity (Foucault, 1972). While in traditional history, the concept of rupture is a strong term that indicates an important change in ideology, belief, or epistemology, see how Scull (1984) or Jones (1972) described "deinstitutionalization", this thesis, by contrast, uses the term "rupture" to describe the prevailing of one discourse over another. In other words, changes in values, beliefs or scientific discoveries will be not used by this thesis as the main causes for

the movement of the psychiatric care from the hospital to the community, but these will be referred to only in relation to the ruptures in the discourses concerning the care of mental illness.

Chapter Plan

Chapters II and III describe the background of the study. Chapter II presents a historical overview of the concept of deinstitutionalization. It then moves on to illustrate the four main scholarly approaches to the investigation of this subject, outlining their main contributions to the definition of deinstitutionalization, and their limits regarding the comprehension of national differences. It than underlies how this study differs from previous accounts.

Chapter III elucidates the theoretical underpinnings of the method applied in this research, explaining how the archaeological method is consistent with my research questions and introducing the main Foucauldian terms used in this study. It will also illustrate my operationalization of Foucault's concept of archaeology, from the selection of the sources to the strategies for presenting my findings, and the main difficulties faced during the research.

The empirical data are presented in chapters IV, V, and VI of this thesis. Chapters are divided on the basis of the types of documents they discuss. As explained, the archaeological investigation challenges the unity of the discourse, and, as such, also the unity of pre-established disciplines, such as psychiatry or law. However, I have decided to keep this unity in the division of the analytical chapters in order to make the comparison between the Italian and English cases stand out even more neatly. Chapter IV focuses primarily on the formation of the psychiatric discourses that

enabled the acceptance of deinstitutionalization practices in Italy and in England. The chapter shows the differences in the national conditions at the core of the ruptures of the psychiatric discourses and how these impacted on the formation of related practices.

Chapter V discusses the formation of the discourses that allowed the approval of the laws that marked the beginning of policies of deinstitutionalization in Italy and England (L. 180/1978 in Italy and the Mental Health Act 1959 in England). Special attention is paid to the strict correlation between the transformation of the national legal and psychiatric discourses and the reorganization of the Italian and British government strategies[2].

Chapter VI focuses upon the formation of the evaluative discourses in the two countries. The chapter examines the national reports and assessments produced at three different historical periods: during the formation of the national deinstitutionalization discourses, after the approval of the laws that ratified the beginning of deinstitutionalization in the two countries, and after the acknowledgment of deinstitutionalization as an "international fact" (Goldman et al., 1982, p.153). Chapter VII discusses my findings. It details my challenging of previous accounts of deinstitutionalization and argues that this transformation cannot be explained as a result of medical progress, a rise of human rights, or due to economic needs only, but that its emergence was characterised by different ruptures and the coexistence of multiple strategies. It explains how the thesis

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[2] This thesis considers the English case within the UK. Though these laws passed by the UK government also apply in the other nations of the UK, I distinguish England as a particular case.

confirms that it is impossible to talk about deinstitutionalization as a univocal process that involved all western countries. The analysis of the formation of the English and Italian discourses on deinstitutionalization showed that their emergence was related to very different historical periods, characterised by very different needs. In the English case, these were traced to the period between the two world wars in relation to increased manpower needs. In the Italian case, needs formed in the 1960s during a phase of rejection of the national government organization established during the fascist era. In this sense, my findings stress the importance of cross-national historical studies in the analysis of mental health care systems.

CHAPTER II: THE MOVEMENT OF PSYCHIATRIC CARE FROM THE ASYLUM TO THE COMMUNITY: A REVIEW OF THE LITERATURE

Introduction

In the twentieth century, the care of people affected by mental illness was completely transformed by the decision of different countries to move psychiatric treatments from being provided mainly in institutions to being largely distributed in the community. "The mass exodus of mentally ill persons from living in hospitals to living in the community" (Lamb, 2001, p.3) has been commonly described as deinstitutionalization (Bachrach, 1976; Goldman et al., 1982). It cannot be reduced to the change of place of care of psychiatric patients. This shift, in fact, included a variety of changes in psychiatric practices, in the representation of the individual affected by mental illness, policies, institutions, and the legal system concerning the management of patients.

The complexity of this essential modification of psychiatric care has been reflected by the number of studies from various disciplines that have tried to explain, describe and evaluate it (Bachrach, 1976; Jones, 1972; Rose, 1986; Scull, 1984; Mechanic and Rochefort, 1990; Busfield, 2000). Deinstitutionalization has been studied as a process, as a goal, as a historical fact, as a social movement, and as a philosophical idea. It has been the subject of a large number of investigations (Novella, 2008; Busfield, 1986; Perry, 2016; O'Driscoll, 1993) characterised by very different approaches. In light of this heterogeneity of methods and results, the aim of this chapter is not to produce a complete and exhaustive review of all of these studies, but rather to illustrate the main existing approaches in order to assess their strengths and limitations. For the purpose of the research, the review has been limited to studies on the deinstitutionalization of psychiatric patients, excluding those on the transformation of care for older people and people with learning or physical disabilities. Moreover, the attempt has been made to select studies considering the European context and, more specifically, England and Italy.

From this review, four main themes or approaches have been framed:

1) "Deinstitutionalization as a goal";
2) "What has been learned from the past";
3) "Decarceration and social control";
4) "Governmentality studies".

It is important to stress that this division is a heuristic one. It has the function to illustrate the main trends in the literature on deinstitutionalization. Some studies de facto overlap or complement one another. The chapter is divided into three main sections. The first section aims to familiarise the reader with the conventional ways in which the English and Italian deinstitutionalization processes have been narrated by previous historical accounts. It also provides an overview of the international use of the concept of deinstitutionalization. The second and main part of the chapter will outline the ways in which this shift in psychiatric care has been studied, the methodological approaches applied by previous studies, how they have contributed to the understanding of this phenomenon, and their main limitations. The last section will summarise the main elements of the approaches reviewed during the chapter and will frame the present study in relation to this literature.

DEINSTITUTIONALIZATION

Tracing the main transformations of the concept

Before tracing the evolution of the mental health care systems in England and in Italy, this section aims to sketch a brief history of deinstitutionalization as a concept and an object of study. The ambition of this account is not to give a definition of the concept, but to illustrate its appearance in the literature and its transformation in the international theoretical and political panorama. Examining the literature on deinstitutionalization, I have identified three main moments in the use of this term: its first appearance and definition in the American context, the introduction of this concept into the international academic debate, and the shift to an international political goal (see Fig. 1 for detail).

| Deinstitutionalization as a series of policies implementated in America in the 1960s | Deinstitutionalization as an international fact during the 1980s | Deinstutionalization as a main goal of an international strategy in Europe (2005) |
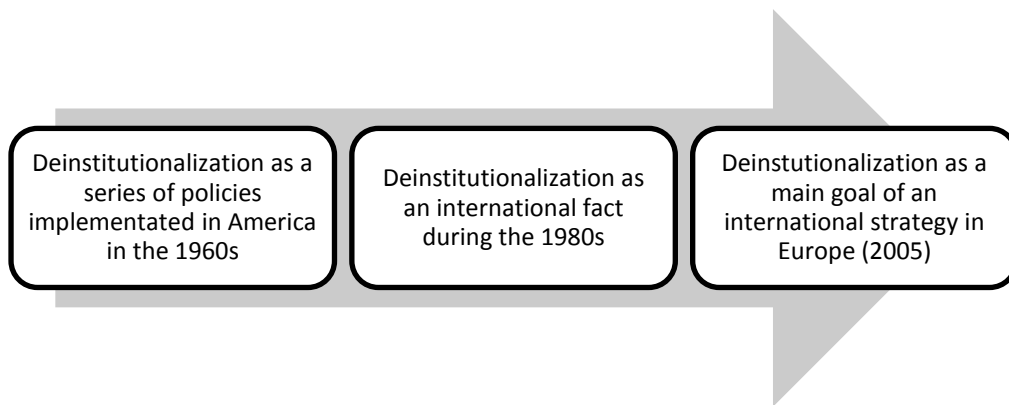
Figure 1-Historical moments in the use of the concept of deinstitutionalization

As already mentioned, until the middle of the twentieth century, the care of the psychiatric patients was completely provided in psychiatric hospitals, and psychiatry was a discipline concerned almost exclusively with mental illness. In the period between the 1950s and the 1970s, this system was subject to a transformation: most western countries, including Italy and England, started the reduction of psychiatric beds and began to offer psychiatric care in contexts other than the long-stay hospitals (Goldman et al., 1982). This transformation was connected to the criticisms that were made against the asylums as places of treatment after WWII (Melling, 1999). Although psychiatric institutions had often been the source of controversy and scandals, by the 1950s they were condemned as spaces unsuitable for treating patients and even spaces that worsened patients' mental health conditions (Scull, 1984, Donnelly, 1992). This coincided also with general criticisms of psychiatric practices (Goodwin, 1997). In the same period, the WHO began its campaign to promote the development of community-based services in order to promote mental health prevention for the population and the rehabilitation of psychiatric patients, rather than their long-term hospitalization (WHO, 1951). It is important to stress that this campaign was not against the hospital tout court, but the WHO was supporting the implementation of mental health policies aimed to prevent hospitalization (WHO, 1951).

Although along different paths, Great Britain and the United States of America were the first countries to initiate the reduction of beds in the psychiatric hospitals (Goldman et al., 1982) in the 1950s and the early 1960s. In one of the first cross-

national comparisons of the American and British trends, Jones (1979, p.552) distinguished the two national processes using different names: while the American transformation was defined as "deinstitutionalization", the English one was described as "running down [i.e., decreasing the size of] the mental hospital". The Italian process was usually known as "psychiatric reform" (Pirella, 1987). Until the end of the 1970s, deinstitutionalization, in fact, was used to describe the policies implemented in America after the approval of the Community Mental Health Centers Act of 1963 under John F. Kennedy. The first sociological analyses of this phenomenon were strictly limited to focus on the American context (see Etzioni, 1975 and Bacharach, 1976). Bacharach (1976) was one of the first sociologists to outline a specific model for the analysis of deinstitutionalization. This movement was defined as a two-step process based on "(1) the eschewal of traditional institutional settings, primarily State hospitals, for the care of the mentally ill, and (2) the concurrent expansion of community-based services for the treatment of these individuals" (Bachrach, 1976, p.1). Starting from this definition, Bachrach (1976) explained that the first part of deinstitutionalization was the result of a mainly "ideal philosophy" (p.2) justified by the dehumanising effect of the hospitals on the patients, while the second needed to be characterised by its operationalization with the creation of services in the community. During this analysis, Bachrach stressed the specificity of this transformation in relation to the American context.

While deinstitutionalization until the end of the 1970s was a strictly American phenomenon, in a special edition of the *International Journal of Mental Health* with the explicative title of *International Perspectives on Deinstitutionalization*, Goldman et al. (1982, p.153) defined it as an "international fact of life in the 1980s". The authors explained that the reduction of psychiatric beds was observable not just in western countries, but also in others, such as the USSR, Colombia and Nigeria (Goldman et al., 1982). From being a label applied to a series of specific policies implemented in America, it was used, in fact, to describe this common trend of reducing the number of beds in psychiatric hospitals (Bennett and Morris, 1982). This shift allowed the transformation of the meaning of deinstitutionalization and

the inclusion under the same concepts of large "variations on…theme" as emphasised by Goldman et al. (1982, p.153), not just in the strategies applied, but even of the philosophies, objectives and intellectual foundations underpinning them.

After this broadening of the concept, deinstitutionalization, as a trend, became the source of further investigations and cross-national comparisons stressing national and international variations and looking for new definitions. Bennet and Morris, for instance, illustrated the divergence of the British deinstitutionalization from Bacharach's model, stressing that although the hospital population in England started to drop around the approval of the Mental Health Act in 1959, "the antecedents of community care…started much earlier" (1982, p.6). According to Bacharach's definition, the American process of deinstitutionalization followed a two-step process, which started with the reduction of the psychiatric population in the hospital and was followed by the creation of services. In England, by contrast, deinstitutionalization had an opposite trend. Italian deinstitutionalization differed further from the American and the English examples (Jones and Poletti, 1985; Scheper-Hughe and Lovell, 1986), with a "more radical direction" (Goldman et al., 1982, p.155) and the complete abolishment of the asylums.

While in the 1980s, the term deinstitutionalization was applied to designate different national policies and trends, which had, as the only commonality, the reduction of psychiatric beds, the beginning of the twenty-first century saw a new transformation in the use of the concept: the ratification of deinstitutionalization as a shared European goal. The promotion of psychiatric services in the community, in correlation to the promotion of mental health policies and the transformation of the national psychiatric legislations, have been consistently supported by the World Health Organization since 1949 (WHO, 1962), but as national policies. In January 2005, by contrast, the ministers of health of the member states in the European region of the World Health Organization signed the *Mental Health Declaration for Europe* and the *Mental Health Action Plan for Europe*. It ratified deinstitutionalization as one of the main goals of mental health care. The concept

of deinstitutionalization was subject to a new transformation: it became the common goal of an international strategy.

Deinstitutionalization is now defined as the transition from institutional to community-based services and as the result of "the shared values of human dignity, equality and respect of human rights" (ec.europa.eu, n.d., para.1). Moreover, "the new policy focus on mental health and deinstitutionalization looks beyond the traditional psychiatric services, to include a public mental health policy and an agenda for inclusion" (euro.who.int, n.d., para.3). Deinstitutionalization has become an integral part of mental health policies and prevention, and the concept has been strictly related to that of social inclusion (WHO, 2013). Thus, the concept of deinstitutionalization now includes not just the movement of psychiatric care and the creation of community-based services, but also the promotion of "the participation of disabled people in leisure activities, employment, education, health, social services" (ec.europa.eu, n.d., para.3). Finally, as an element of the Cohesion Policy strategy 2014-2020, an equalization of its implementations among the European member states is expected. This new use of the concept in the European context is noteworthy as it transforms deinstitutionalization from being one possible strategy for the care of people with mental illness to being the only one – to being a right rather than a policy.

These variations impacted on the studies (Fackhouri and Priebe, 2002; Medeiros et al., 2008; The Economist Intelligence Unit, 2014; Shen and Snowden, 2014) on this phenomenon, reviving interest in the matter during the time, but also making it the object of various inquiries from different perspectives. Deinstitutionalization, in fact, has been investigated from various angles: as an important social-historical change, as a goal to be achieved, in terms of services and policies, and as a way of governing the population. While the second part of this chapter will seek to review this extensive literature on deinstitutionalization, the next section aims to familiarise the reader with the English and Italian mental health care systems and the broad historical contexts where these policies were enacted.

The exodus of psychiatric patients in England and in Italy

This section seeks to set the main deinstitutionalization policies that led to the formation of the actual mental health care systems in England and in Italy. It is not supposed to be a complete account, but it aims to give the reader a broad insight into how the English and Italian deinstitutionalization processes have been described and some of the main issues faced by the current systems.

Jones described the process of deinstitutionalization in England as "full of twists and turns, of unintended consequences and unexpected outcomes" (1987, p.94). The law that ratified the actual implementation of the deinstitutionalization process was the Mental Health Act 1959, but the reduction of psychiatric beds in England started in 1955 (Bennet and Morrison, 1983). England was the first country to attempt the implementation of a mental health care system in the community as suggested by the WHO in 1951 (WHO, 1962). Before then, the English system was regulated by three main laws, namely the Lunacy Act, the Mental Treatment and the Mental Deficiency Act, that had all as a central element the psychiatric hospital as a place of custody and treatment. These laws were all abolished with the approval of the Mental Health Act 1959 (Goodwin, 1997). Although some authors have pointed out that community care for people affected by mental illness has always coexisted with the asylum in England (Bartlett and Wright, 1999), this act ratified its formal regulation (Bennet and Morris, 1983), and the multiplication of health professionals establishing a mental health care system characterised by the coexistence of community based services and psychiatric hospitals (Rose, 1986; Goodwin, 1997; Killaspy, 2006), where the latter was supposed to be the last resort (Royal Commission, 1957). After the approval of the Mental Health Act 1959 and the introduction of the community care in the health care system, the English mental health policies took a more radical strategy in relation to the use of psychiatric hospitals. In 1961, Enoch Powell predicted a reduction of more than half of the psychiatric beds by the end of 1975 (Jones, 1972).

The goal of Powell's strategy was never achieved, but more radical political policies were started in the 1970s. In 1971, 'Hospital Services for the Mentally Ill' proposed

the complete abolition of the mental hospital system (Killaspy, 2006) replacing them with out-patients and short-stay accommodations. In order to enable this transformation, in 1975, "Better services for the mentally ill" promoted the creation of a psychiatric service completely community-based in order to establish a continuum of care from hospital to the care in the community (Turner, 2004).

The implementation of these policies was explained by experts in social policy as the "outcome of a number of trends that have different objectives, emphases, and intellectual foundations" (Bennet and Morris, 1983, p. 5). The creation of psychotropic drugs (Shorter, 1997; Jones, 1993), the rise of a movement for alternative uses of the psychiatric hospitals, such as the open door and day-hospital movements (Jones, 1972; Farndale, 1961), a transformation in the perception of mental illness and an increase in the acceptance of people affected by mental health issues in the community (Jones, 1952; Rose, 1986; Goodwin, 1997) after the psychiatric experiences developed during WWII (Rees, 1943; Jones, 1952).

These advances in psychiatric practices were also supported by radical analyses of mental illness and critiques of the efficacy of psychiatric institutions as therapeutic settings (Miller and Rose, 1986; Jones, 1972; Crossley, 2006). In the 1960s, sociologists such as Goffman and psychiatrists like Barton supported with evidence the negative impact of asylums on the psychiatric patients. In the same period, the anti-psychiatric movement, led by Cooper and Laing, started its experiments for the renovation of psychiatry (Crossley, 2006; Miller, 1986). Moreover, the implementation of community care services was supposed to be less expensive than long-stay admissions, thus, this strategy would have reduced the high costs of the NHS (Jones, 1972; Scull, 1984).

However, it is important to point out that "large-scale closures did not start until the 1980s, with the first closure in 1986" (Kings Fund, 2015), and the development of the community care was very slow, as illustrated in the Griffith report at the end the 1980s (Turner, 2004).

The failure to provide a reliable network of services in the community after the discharge of psychiatric patients in the community coincided with a renewed interest in the control of mental illness (Rollin, 1976; Jones, 1980). In 1983, a new Mental Health Act was approved – with the aim to increase legal safeguards for patients admitted under the compulsory power (Gostin, 1983). While this law was described by some authors as an attempt to protect patients' rights (Gostin, 1983), others, by contrast, stressed that this law marked the return of the legalism approach that characterised lunacy acts (Jones, 1980; Rose, 1985). Moreover, it reconsidered the need for psychiatric hospitals and restated the needs for compulsory power in the treatment of psychiatric patients. In the 1990s, the case of Christopher Clunis, who murdered Christopher Zito, was associated with the failure of the mental health care system (Killaspy, 2006). As a consequence, new policies, namely the Care programme approach (CPA), were approved in the attempt to increase the control and management of the psychiatric patients after their discharge from the psychiatric hospitals and their care in the community (Killaspy, 2006). In 1999, the Department of Health launched the National Services Framework for Mental Health: a 10-year programme aimed to achieve seven standards on mental health services all around England (Boardman and Parsonage, 2009).

The present English mental health care system is based on the coexistence of psychiatric hospitals, community mental health centres, and out-patient services. Mental health care policies are still central to the English political agenda. In 2011, a cross-government strategy, namely 'No Health Without Mental Health', was launched with the aim to improve the physical health of people with mental ill health (HM Government, 2011), and in 2014, the Care Act set local authorities' responsibilities in assessing people's needs and their eligibility for care and support. Even more recently, in March 2015, the Mental Health Taskforce was formed with the aim of developing a five-year strategy on mental health (NHS England, 2015).

While England was scored as one of the best European countries in relation to an index assessing the level of community integration of people affected by mental

illness (The Economist Intelligence Unit, 2014), other studies pointed out a new process of reinstitutionalization of patients affected by mental illness in England (Turner 2004). According to Turner (2004), "while the number of beds has been falling officially, the number in secure units are rising" (p.3). Moreover, the number of compulsory admission "exceeded 63 000 in 2015–16, a 9% increase on the previous year and an increase of around 43% since the introduction of the 2007 Mental Health Act (MHA)" (Weich et al. 2017, p.619)

Mental Health Act 1959 | Better services for the mentally ill 1975 | Mental Health Act 1983 | Care programme approach 1991 | Mental Health Act 2007 | Care Act 2014
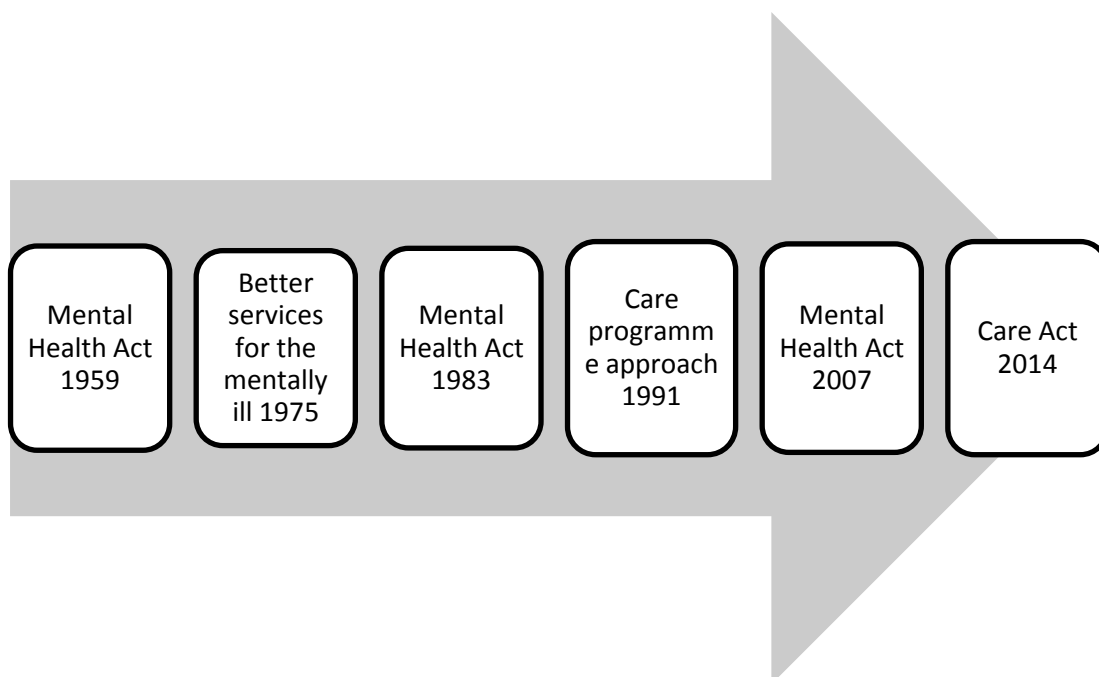
Figure 2: The evolution of the English mental health care system

In Italy, the decline of beds started at the beginning of the 1960s (Pirella, 1987), but the law which ratified the closure of the psychiatric hospitals was approved in 1978, twenty years after the English one. Before then, the Italian mental health care system was completely based on asylums (in Italian "manicomi") and the only law regulating the psychiatric system was Legge n. 36/1904, which remained without changes until 1968. According to Ramon and Giannichedda (1991), the conditions of the Italian psychiatric hospitals (manicomi) were much more uncomfortable than the English one. While the English systems after the Second World War started a period of reconstruction of the psychiatric hospitals, the Italian manicomi, by

contrast, were not objects of renovation (Ramon and Giannichedda, 1991). In the 1950s, two proposals to change the psychiatric systems were discussed in the Italian parliament but neither was approved (Canosa, 1979).

In the 1960s, the transformations that were involving all the European countries, such as the Mental Health Act in England, inspired the critiques against the actual state of the psychiatric hospitals and L.36/1904 (Donnelly, 1992, Forgacs, 2014). The first step of the Italian government to renew the Italian system was the approval of Legge n. 431 in 1968 (Costantino and Orlando, 1982). This provisional law started the process of medicalization of the psychiatric system: L. 36/1906 was predominantly a custodian one (Castel et al., 1982), while Legge n.431/1968 introduced health standards to be achieved, the possibility of voluntary admission, and the abolition of the criminal record for those admitted in the hospital. However, the real transformation of the Italian psychiatric system was marked by the approval of Legge n.180 in 1978. This law was considered a radical law by international experts (Goldman et al. 1982; Bennett, 1985; Goodwin, 1997) because it completely abolished the existence of psychiatric hospitals. The uniqueness of the Italian reform was also characterised by the political and social conditions in which it developed (Bennett, 1985; Jones and Poletti, 1985).

The Italian process of deinstitutionalization coincided with different factors: first of all, a radical transformation of psychiatric theory and practice (Manacorda et al., 1977). Until the 1960s, Italian psychiatry was based on a completely biological approach to mental illness (Manacorda et al., 1977; Canosa, 1979; Guarnieri, 1991; Donnelly, 1992). The deinstitutionalization process coincided with the dissatisfaction of young psychiatrists to this organicist approach to mental illness (Donnelly, 1992), especially after entering into contact with the new European experiences (De Salvia and Crepet, 1982), such as the therapeutic community or psychoanalysis (Ramon and Giannichedda, 1991). Drawing on a phenomenological approach to mental illness, which stressed the role of subjective experience in the development of psychiatric disturbances, rather than physical and neurological causes, Italian psychiatrists started to pilot experiments in the treatment of mental

illness in the psychiatric hospitals (Donnelly, 1992; Foot, 2014a). One of the most popular examples was the one started in Gorizia by Basaglia (Goodwin, 1997).

The second factor was the creation of a movement of professionals, namely Psichiatria Democratica [PD] (Goodwin, 1997). PD supported the Idea that mental illness was strictly related to the social condition of the person and, more specifically, psychiatric hospitals were the means used by the government to exclude unproductive people from society (Donnelly, 1992). Although PD was "neither a professional association, a trade union nor a political party" (Ramon and Giannichedda, 1991, p.13), the movement found the support of working movements and the communist party in the protection of disadvantaged people such as those affected by mental illness. The law, in fact, was supported by the Partito Comunista Italiano [PCI], which was elected for the first time to the Italian parliament.

The third factor that contributed to the approval of L. 180/1978 was the broader process of social transformation of the Italian system in which the law was included. L. 180/1978 was, in fact, just one of the various laws approved in the 1970s that radically changed the Italian social system (e.g. the law on divorce, abortion, the approval of the working union rights paper, the elimination of any special class for children with disabilities) (Donnelly, 1992). In 1977, the Italian parliament was drafting the law for the creation of the National Public Health System - Sistema Sanitario Nazionale [SSN]). Until then, the Italian health system was still based on insurances as during the Fascist era. This new law would have abolished L. 36/1904 and ratified the creation of a new psychiatric system without psychiatric hospitals. However, this draft did not satisfy completely all parties involved in the decisional process: while more progressive groups, such as PD, were unhappy because the law provided the existence of a compulsory power for the treatment of some patients, more traditional parties deemed too radical the abolishment of the psychiatric hospitals. Due to this immobility in the decisional process, the Partito Radicale, a very small political party, challenged the Italian parliamentary system proposing a referendum for the abolishment of L. 36/1904

(Morabito, 1977). This was only one of the eight referendums proposed by the Radical Party in the 1970s in order to reduce the political parties' decisional power using the referendum as a form of direct democracy (Morabito, 1977). However, the petition for the abolishment of the psychiatric hospitals coincided with a tragic moment in Italian history: the Moro case3. The assassination of Aldo Moro shocked the Italian population and this made their vote unpredictable: despite the 1960s were characterised by the support of the public opinion to the abolishment of the psychiatric hospitals, the last terroristic events led to the support of the public opinion for more restrictive security measures (Canosa, 1979). In order to avoid the petition, which would have left the Italian country or with a very old regulation (L. 36/1904) or without any regulation concerning the management of mental illness, the parliament rushed the approval of Law 180 in 1978 despite the general disagreement on the adequacy of the law (Canosa, 1979; Costantino and Orlando, 1982). L. 180/1978 did not provide any suggestions or guidelines for the creation of community-based services for people affected by mental illness but left the freedom to manage this transformation completely to the local mental health authorities (Rossi, 2016). Moreover, the law was approved before the creation of the national health system [SSN], despite the fact it implied its existence (Costantino and Orlando, 1982). Although the referendum was never done, it is generally acknowledged its central function in the process of approval of L. 180/1978 (Canosa, 1979; Costantino and Orlando, 1982; Donnelly, 1992).

In 1978, the SSN was established with the approval of Legge n.833. Although L. 180/1978 was included in the former and its main articles rested unchanged. L. 833/78 even reinforced the regionalization of the health services. As a consequence, each region was left with the freedom to decide about the provision and regulation of mental health services. This resulted in a mental health care system characterised by a high level of fragmentation and variety in the country (Rossi, 2014). New models were experimented with on the local level, but while

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3 Aldo Moro was a politician who was kidnapped and killed by the Brigade Rosse in 1978. See Hof, T. (2013). The Moro Affair - Left-Wing Terrorism and Conspiracy in Italy in the Late 1970s. This event was only one of the various political terroristic attacks that shocked Italy between the 1970s and 1980s. This period was known as "anni di piombo".

some of them are internationally considered as best practices, such as Trieste community mental health care (Mezzina, 2014), other areas were left without any public service (Jones and Poletti, 1985).

In the need to make mental health care services accessible to all, the Italian government approved a national plan, namely Progetto Obiettivo "Tutela della salute mentale" in 1994, 16 years after L. 180/1978. This was the first strategy on the national level aimed to provide criteria and guidelines for the harmonization and the creation of a national structure of mental health services. The plan was a confirmation of the values at the core of L. 180/1978 (Rossi, 2016) and it led to the complete closure of the few psychiatric hospitals still active in Italy. A further national plan was produced at the end of the 1990s in order to consolidate the national plan of 1994. In addition, Legge n.81 of 2014 ratified the complete closure of the security psychiatric units - Ospedali psichiatrici giudiziari [OPG], which were untouched by L. 180. Although Italy seems to have achieved the complete closure of the psychiatric hospitals, which is one of the main aims of deinstitutionalization, according to MHI Index it was scored as one of the lowest European countries in relation to the integration of people affected by mental illness (The Economist Intelligence Unit, 2014). Although, the various attempts of the Italian government to equalise access to the services all around the country, one of the main issues rests in the high level of differentiation among the regions (Barbui et al., 2018).
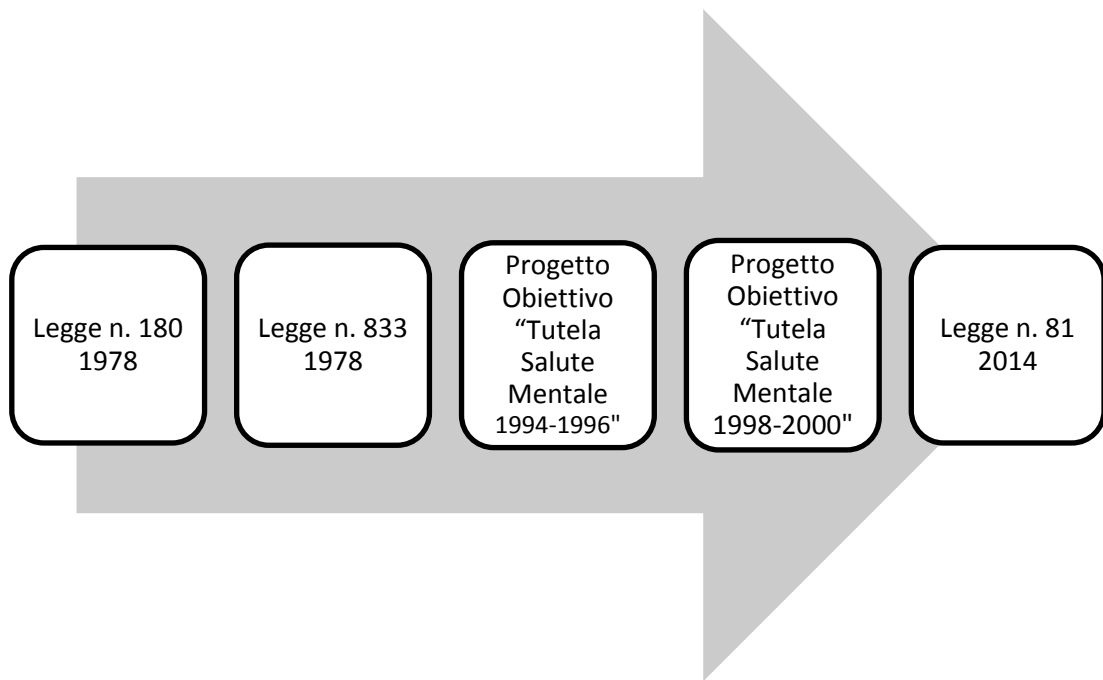
Figure 3: The evolution of the Italian mental health care system

The aim of the next section is not to offer a complete review of all investigations on the subject, but to provide a general overview of the multiple existing approaches. Specifically, it will seek to outline critically how deinstitutionalization has been studied by previous studies, the differences and commonalities of earlier investigations, and their weakness, in order to justify a further inquiry into this matter.

MAIN APPROACHES TO THE STUDY OF DEINSTITUTIONALIZATION

Deinstitutionalization as a goal

The majority of the studies concerning the movement of psychiatric care from hospitals to the community investigated this phenomenon as a standard to be achieved through policies and psychiatric interventions. In this category, one can include all studies aiming to examine and assess the content and implementation of the policies and services for the movement of psychiatric patients from the care in institutions into the community. Evaluative studies are mainly conducted by experts in social policy or those working in fields of mental health, such as medics and psychiatrists, in order to assess the performance or effectiveness or efficacy of specific services and national strategies implemented for the achievement of

deinstitutionalization. Such studies have contributed to the construction of outcomes and indexes for assessing the performance of policy programmes and services. Moreover, their analyses impacted on the definitions of objectives and expectations of deinstitutionalization as a strategy, and in terms of practices. In other words, the main findings of these studies were the level of successes and failures of given policies and the delineation of new areas of intervention. In relation to the goal set by the European Community in 2005, it is possible to include in this category of studies also those focused on the search and definition of best practices among the European community member countries in order to favour their exchange and equalization.

As seen in the previous subsection, deinstitutionalization was often associated with the population of psychiatric patients in psychiatric hospitals. Thus, the most popular variable for assessing the movement of psychiatric care was related to the distribution of beds for psychiatric patients in institutional settings. A general reduction among the western European countries in the number of beds in the psychiatric hospitals (Fackhouri and Priebe, 2002; Medeiros et al., 2008) and the relocation of a high number of individuals "to other settings such as general hospitals or various forms of community-based supported living establishments, or…returned to their family homes" (McDaid and Thornicroft, 2005, p.2) has been acknowledged by these assessments since the beginning of deinstitutionalization. Specifically, these results were in line also with studies conducted in the Italian and English contexts (de Girolamo et al., 2007; Johnson et al., 2001; Glover et al., 2006; Burti, 2001), with only one big difference: in Italy, psychiatric care is no longer provided in psychiatric hospitals (Medeiros et al., 2008). Looking at the bed rates in institutions, other assessments, by contrast, have highlighted an increase in the number of forensic beds, supervised housing and prisons in all the European countries (Priebe et al., 2008). This new tendency has been named the *reinstitutionalization* of patients (Priebe and Turner, 2003) and understood as a visible sign of the failure of the deinstitutionalization approach to psychiatric care (Fakhoury and Priebe, 2007). While some studies have looked at beds as the representation of the failure or success of deinstitutionalization as a general

political and therapeutic strategy to mental illness, other studies comparing the European rates of deinstitutionalization speak rather of the movement of psychiatric care as "a work in progress" process (The Economist Intelligence Unit, 2014, p.19). In other words, the latter approach, rather than looking at deinstitutionalization as an effective or ineffective strategy for psychiatric care, has involved assessing the level of implementation of deinstitutionalization as a common European strategy, stressing that the common trend of most European countries towards community-based care is a signal that one is going in the right direction toward the realization of this goal (The Economist Intelligence Unit, 2014). It is important to point out an essential difference between these two ways of approaching deinstitutionalization: while the former seeks to assess the efficacy of deinstitutionalization as one possible strategy for mental illness, the latter looks at deinstitutionalization as a goal itself.

This lack of a shared understanding and definition of deinstitutionalization impacts clearly on the consistency of the results of the studies that I have included in this category. This is even clearer if we consider that beds were not the only criterion applied to evaluate the implementation of deinstitutionalization. Other studies, in fact, pointed out the impossibility of reducing deinstitutionalization to the number of beds, and they have attempted the evaluation of the implementation of these policies with more complex models. Salisbury et al. (2016), for instance, outlined the main "markers of deinstitutionalisation" (p.2) in order to build an objective tool to evaluate the level of deinstitutionalization among the European countries. In this sense, deinstitutionalization was described as the achievement of certain "standards of care" (Salisbury et al., 2016, p.2), such as the availability of primary care services, trained staff in mental health and accessibility of psychotropic medication. The result of the application of this index was a high level of fragmentation between the European countries in the types of services, and the availability of specialised mental health staff (Salisbury et al., 2016). In contrast with the aforementioned analysis, this analysis read the fragmentation as the sign of an unsuccessful European political strategy. Other evaluations comparing hospital services to the community-based approach, by contrast, have defined

deinstitutionalization as a complete success on the basis of costs and patients' satisfaction (Rothbard and Kuno, 2000).

As seen, deinstitutionalization has also been associated with therapeutic goals and, in particular, with the reduction of the social isolation of psychiatric patients. In this sense, studies showed the success of deinstitutionalization in relation to the improvement of patients' social relationships (McInerney et al., 2010), higher quality of life (Salisbury et al., 2017), and fewer needs (Priebe et al., 2002) compared to those in psychiatric hospitals. Similar studies have also been conducted at the national level in the UK (Leff et al, 1996; Goldberg, 1999) and in Italy (de Girolamo and Cozza, 2000), showing similar trends. However, Fakhoury et al. (2002) pointed out that deinstitutionalization impacted negatively on some categories of patients, such as the new chronic patients or with comorbid disorders, new long-stay patients, and people with a learning disability. They explained that while the main goal of policies became the creation of community-based services and the integration of individuals affected by mental illness, no attention was given to improving the quality of life and receptiveness of housing services for those patients who still required residential services (Fakhouri et al., 2002).

While evaluative studies contributed to the understanding and representation of the actual state of deinstitutionalization in Europe, it is noticeable that one of the main limitations of this type of study is that their results are quite contradictory. This is due to the lack of a shared definition of deinstitutionalization (Bachrach, 1989; Salisbury et al., 2016) and of defined programmes to evaluate (Thornicroft and Bebbington, 1989) these policies. Each of these studies, in fact, underpins very specific expectations of deinstitutionalization resulting in a heterogeneity of methods and results. In this sense, the only common result is the fact that deinstitutionalization differs from country to country, but cross-national comparative studies based on national statistics, or evaluative studies conducted on the national level, are not reliable due to the use of different methods and study designs (Becker and Kilian, 2006). Evaluative studies were able to highlight the international heterogeneity of mental health and deinstitutionalization policies (Goldman et al., 1982, p.157), but they were unable to establish the reason of this

variety, which has often been broadly explained as due to differences in "national traditions and socio-cultural context, the availability of resources and financial incentives as well as specific features of the given social welfare and health care systems" (Fakhoury and Priebe, 2002, p.191). Historical differences, national contexts, different models and services were used as variables in comparative studies to discover best models and practices or to evaluate failures and successes (Fakhoury and Priebe, 2002; Goldsmith et al., 1982), but not with the aim of explaining the reasons for these differences.

Except for a few attempts, such as Shen and Snowden's work[4] (2014), this approach can be criticised for the complete lack of attention to the processes that led to deinstitutionalization. Marquant and Gonzalez (2018), for instance, comparing the process of deinstitutionalization to the transinstitutionalization phenomena, have stressed the importance of not reducing this to the transformation in bed rates. They emphasised, by contrast, the importance of considering other elements, such as differences in the national forms of community-based care, changes in the population and national legislation. Others have stressed the impossibility of studying deinstitutionalization without considering the historical context (Jones, 1979) and the lack of cross-national studies taking into account the historical national differences in the implementation of these policies (Shorter, 2007).

What has been learned from the past?

This category includes a broad variety of studies conducted in social history and social policy. Goodwin (1997) defined this stance in the study of deinstitutionalization as the "orthodox approach", in order to distinguish it from the critical one. These studies take a "conventional understanding of policy change" (Goodwin, 1997, p.29) sharing the idea that social policies and political decisions are the product of analysis based on knowledge, interest, ideologies, and values, and that a historical assessment of the ideas and human processes which led to the current enactment can help to understand the causes of failures in the present. The past is questioned in order to understand the reasons why a certain policy was

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[4] See Shen, G.C. &, Snowden, L.R. (2014). Institutionalization of deinstitutionalization: a cross-national analysis of mental health system reform. *International Journal of Mental Health Systems*. 8(1), 1–23.

implemented based on the assumption that policies are the product of rational decisions. Research within this area involves investigating the history, looking for origins, causes, motivations, and assumptions, to explain the national and international movement of psychiatric care from the hospital into the community. To a certain extent, this line of study is complementary to the previous one as it supports the definition of criteria and expectations for evaluating failures and successes of deinstitutionalization. In other words, while the previous trend focused on deinstitutionalization in order to assess its effect in the present, studies included in this subsection investigate the reasons why deinstitutionalization started and what kind of actions and choices determined possible failures in the present implementation.

Since the 1970s, historical studies have played a central function in the debates about psychiatry, mental health laws and asylums (Porter, 1991; Guarnieri, 1991). Historical interest rose in correspondence with the criticisms of psychiatry and mental illness by anti-psychiatric movements both in England and in Italy (Porter, 1991; Guarnieri, 1991). In particular, Melling dated the beginning of "detailed investigation into the workings of asylums from the publication of Foucault's [work]" (2013, p.1). According to Melling (1999, p.1), Foucault's account on madness and society has been the object of various critiques and historians have attempted to "refine and correct the extravagant historical inaccuracies" of the author. Great attention was given to the real functions of psychiatric institutions in society (Melling, 1999), to the development of psychiatry as a medical profession (Busfield, 1986) and to the patients themselves (Porter, 1999). Some historical narratives pointed out the bright side of institutions: the humanitarian functions and beliefs that were behind the rise of the asylum, rather than just focusing on the security function played by psychiatric hospitals (Bynum and Porter, 1985; Forsythe and Melling, 1999).

Although the majority of the historical studies on psychiatry still stay enclosed within the asylum's walls, there is a call for historians to "deinstitutionalize" the history of psychiatry (Eghigian, 2011). More specifically, a great deal of attention

has also been paid to the causes that led to the movement of psychiatric care from the asylums to the community.

Kathleen Jones' series of books on the British mental health services are quite a striking example of the theoretical assumptions underpinning this approach. As a social policy expert, Jones (1979) criticised studies taking into account only the present implementation of deinstitutionalization, stressing that it is an erroneous assumption that "mental health services could be studied in isolation from both their historical and their sociological contexts" (pp.552-553). Her books, by contrast, sought to explain in "plain language" the transformation of the "social policy for mentally ill people in England over some 250 years" (Jones, 1993, p.4). The author seeks to re-write history, supporting her arguments with a large number of references from various sources, in particular official documents. The idea is that history, like any natural process, is the result of a cause-effect process, and as such, it can be described objectively. On the other hand, while the author claims to remain neutral during her account, it is possible to notice that her narration adapts in relation to specific problems that she tries to tackle through her historical research. In *Asylums and After: A Revised History of the Mental Health Services* (1993)*,* Jones explains the need to rewrite her previous book *A History of the Mental Health Services* (1972) not just to extend the historical period under analysis, but to look at the history of mental health services in the light of contemporary issues concerning psychiatric care (Jones, 1993).

This analytical category shares with the previous approach the assumption that accurate analysis and calculation can control "unexpected outcomes" (Jones, 1993, p.94) and avoid mistakes. However, while the previous approach aims to assess the present implementation of policies and services, this approach analyses the process that led to the definition of such policies. At the core of this approach sits the assumption that deinstitutionalization was the result of a series of agencies, such as professional interests, managerial techniques and public opinion. On the other hand, these agencies were considered as the product of a conscious human being actively working to define, shape and implement the present idea of mental illness and psychiatric services. Thus, the assumption at the basis of this analytical

category is that it is possible to retrace the real origins of changes looking at history. History is explained as a succession of opposite trends, and each period can be explained as a consequence of the other. For instance, Jones splits the process of formation of the English mental health care system into three main periods: "the growth of public concern" (Jones, 1972, p.25), which culminated in the Lunatics Act of 1845; the transformation from "the triumph of legalism" (Jones, 1972, p.153) to the creation of the NHS; and the Mental Health Act 1959 and formation of community care. Each of these periods is explained as the triumph of a specific ideology that determined a sudden transformation. Specifically, the history of the English psychiatric system was often described by conventional historical accounts "as a pendulum swinging between two opposing schools of thought – legalism and professional discretion" (Gostin, 1983, p.47), while the Italian psychiatric reform was described as the result of a "new democratic spirit" (Babini, 2009, p.181, my translation).

Contrary to the critical historiographic approaches, this analytical category does not consider political decisions as something hidden to be unrevealed. Rather, it is possible to retrace the human agencies supporting them and the causes that enabled their triumph or rejection. For instance, the approval of the Mental Health Act 1959 in England and Legge 180 in Italy are explained as the result of medical progress (Jones, 1972; Shorter, 1997; Benassi, 2014). The majority of the historical accounts stress the role played by the psychiatric experience during WWII, which enabled the acceptance of the curability of mental illness (Kritsotaki et al., 2016). Shorter (1997), by contrast, associated the rise of deinstitutionalization policies with the revamping of the biological approach to psychiatry and the rise in the use of psychotropic treatments.

Other authors underscored the role played by the assumption that the care in the community was cheaper in the political decision to reduce psychiatric hospitals (Jones, 1972; Hawks, 1975; Pirella, 1987; Daly and Lewys, 2000). A great emphasis was given also to the role played by the social movements promoting human rights and critique with the custodial function of psychiatry and hospitals (Jones, 1972; Bennet and Morrison, 1982; Turner, 2004; Babini, 2009). In this sense, it is

interesting to notice that the rise of the Italian anti-institutional movements and the beginning of the psychiatric reform are often explained as the result of the larger transformation in the mental health care systems in the other Western countries (Donnelly, 1992; Forgacs, 2014).

Moreover, some accounts described deinstitutionalization as a rupture characterised by the creation of legislation aiming to reduce psychiatric beds and the creation of community mental health (Killaspy, 2006) and the relation of these policies with the development of welfare and health services (Busfield, 1986). Other authors, by contrast, pointed out that the management of mental illness in England was never only a matter of asylum (Bartlett and Wright, 1999), but that it was possible to notice the existence of a mixed economy and community support since insanity was considered a medical condition (Smith, 1999). Thus, the development of the community care was not considered as a rupture with the past, but rather as a formalization of an existing reality (Bartlett and Wright, 1999).

Even with some discrepancies between the interpretations of the causalities or the relevance given to one element rather than another, Jones' results are in line with most of the "conventional" accounts on deinstitutionalization (Novella, 2008, p.305). This is due to the fact that these causes are seen as objective facts, and investigating history enables just the description of "how succeeding generations" (Jones, 1972, p.xiii) have addressed the problem of the care of people affected by mental illness in relation to new knowledge, ideologies and social problems.

Mental illness and the knowledge related to it are considered by studies of this type as a shared element between western countries. This approach to history has impacted also on the way in which international differences have been investigated with this approach. Jones, for instance, has attempted several cross-national analyses of the deinstitutionalization experiences (1979), including comparisons of the Italian psychiatric reform with the English one (Jones, 1988; Jones and Poletti, 1985). Her writings acknowledge the "different political, social and economic systems" (Jones, 1988, p.99) that characterised the two countries and the differences in the Italian and British implementations of the mental health care systems, such as the radical decision of the former to close down all the psychiatric

hospitals. Yet these elements are considered as secondary elements. Instead, Jones stresses the commonalities of these decisional processes to explain the larger process of deinstitutionalization worldwide[5] (see Jones, 1979; Jones, 1988).

The "search for coherence" (Jones, 1988, p.130) and "the quest for accurate explanatory models" (Novella, 2008, p.313) of deinstitutionalization in the western countries, free from "localism" and "partialism" (Novella, 2008, p.312), were the main aims of this account. Conventional accounts also reveal an attempt to emphasise the role of international influence in the development of deinstitutionalization (Turner, 2004; Babini, 2009), rather than to focus on cross-national comparisons of national conditions. However, it is worth mentioning in this category Goodwin's comparative study (1997). Although it is not a completely historiographic study, the author seeks to understand the factors that impacted on the creation of the actual differences in the mental health care systems among the Western countries. Goodwin's work is inspiring, as it acknowledges the great variety of post-war mental health care policies. More specifically, the author acknowledges three main patterns of mental health policy developments: the pattern of the countries characterised by a liberal regime, such as England and America; those that followed a conservative regime, such as Germany; and countries in the social democratic regime, such as Sweden. While the author seeks to address the problem of the differences among the countries looking at the national historical contexts, there is still a tendency to build a model in which to include national differences, rather than focusing on them. In addition, concepts are used in the analysis without considering international differences, for instance, community care is used indistinctively among all countries without considering the fact that is a specific feature of the English mental health care system (Bennett and Morrison, 1982).

Although conventional studies on deinstitutionalization acknowledge that mental health care systems are formed in "response to the society they serve" (Jones, 1972, p.352), the attempt to build a comprehensive and consistent model has

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[5] This particular study included in the comparison also the Chinese and American experiences.

generated a tendency in these studies to flatten any differences. The search for the real origin of deinstitutionalization as a single and shared event, the focus on analogous international trends, and the search for historical similarities have led these studies to incorporate local and different implementations of deinstitutionalization into an indistinct frame, rather than to highlight their differences, hindering any effective comparative analysis. Moreover, the attempt to build a fixed periodization common to different countries led to criticism concerning the correctness of cause-effect explanations. For instance, it has often been pointed out that the use of drugs was subsequent to the beginning of the process of moving services out of the institutions (Scull, 1984; Busfield, 1986; Novella, 2008). Gostin (1983) and Rose (1985) also criticised the tendency of this historiographic approach to reduce the history of mental health legislation to a simplistic opposition between the legalistic approach and medical discretion, without explaining all the relations involved in these discourses. Another criticism of this historiographic approach concerns the assumption of progress and knowledge as objective factors. Rose (1986, p.53), for instance, accuses such "standard histories" of psychiatric services of reductionism, as they explain deinstitutionalization in terms of "developments in science and conscience" without considering the complexity of relations implied in the formation of knowledge.

While evaluative studies on deinstitutionalization policies focus on the grade of success of present services, conventional accounts investigate history in order to comprehend the processes that have led to the present implementation and the causes of their failures. The aim is to outline a comprehensive model capable of explaining the development of deinstitutionalization policies in western societies to address the problem of mental illness and provide new insights for their improvement.

Decarceration and social control

In this section, I will focus on a range of studies produced mainly by sociologists and characterised by a critical approach to the historical causes of deinstitutionalization

retraced by the previous accounts. While conventional historiographic approaches see policies as the product of visible processes, this category, by contrast, explains them as a way for the dominant or political class to maintain the social order, through the control of deviance. Thus, history is studied to unravel the hidden functions of psychiatric services in social control and production, rather than to outline a comprehensive model to explain deinstitutionalization. In this frame, even psychiatric knowledge is challenged as subordinated to economic and political necessities. The name of this category was given by the two most known models of deinstitutionalization produced by Scull (1984) and Conrad (1979; 1980).

Decarceration was defined as "a state-sponsored effort to de-institutionalize deviant populations…[and as] a central element in the societal control practices of a number of advanced capitalist societies" (Scull, 1984, p.3). Rejecting the idea of policies as a result of rational or humanitarian strategies, Scull applied Marxist historiography to show the strategies applied by the dominant classes to maintain the status quo. The author ascribed a central role to structural factors in the development of the deinstitutionalization policies. Thus deinstitutionalization is explained as a necessity of capitalism, rather than as a combination of multiple causes and human agencies. Through an attentive historical account of deinstitutionalization in America and in England, Scull (1984) challenges all the justifications that supported deinstitutionalization policies, such as the improvement of psychiatric care or the function of the introduction of psycho drugs. In particular, Scull proposes an accurate analysis of the arguments proposed by the decarceration movements in the nineteenth and twentieth centuries in order to illustrate their similarities and support his thesis that deinstitutionalization was not the result of changes in knowledge or morality, but rather the result of "structural pressures to curtail sharply the costly system of segregative control" (Scull, 1984, p.152). All the humanitarian and therapeutic discourses were only "ideological camouflage, allowing economy to masquerade as benevolence and neglect as tolerance" (Scull, 1984, p.152). Resonant with the studies summarised in the previous subsection, decarceration theory also explains history as linear and characterised by trends and describes deinstitutionalization as a sudden change. On

the other hand, while conventional accounts have used multiple causal models to explain it, decarceration approach acknowledges the economic system as the only and real cause of deinstitutionalization. In other words, all other variables acknowledged by the accounts mentioned above are here considered as a way to hide the real reason for deinstitutionalization policies and lend it an acceptable justification.

Similarly, Basaglia (2014) and Warner (1994) have used Marxist ideas to argue that mental health reforms, which allowed the movement of patients from the asylum to the community, and the creation of alternative treatments, such the Maxwell Jones's therapeutic community, were the result of changes in the economy and the development of the labour market. Basaglia (2014), for instance, illustrates the similarities between the assumptions underpinning the therapeutic community and moral treatment to argue that the only difference after deinstitutionalization was the economic need to make patients productive. In this sense, it is interesting to note the comparative attempt that Basaglia makes between the Italian and English psychiatric practices during the 1960s. He points out that the differences in the implementation of psychiatric services in the community between the two countries were due to different economies and systems of production. While the English context activated a full employment policy and, for this reason, required that all members were productive in the community, the Italian one, characterised by a high rate of unemployment, required the exclusion of unproductive members of society, such as the psychiatric patients, to maintain order (Basaglia, 2014).

While Marxist studies have ascribed a central role to the economy in the transformation of the form of control and regulation of social deviance, other critical studies have stressed the functions of the state in the definition of professional practices. Conrad (1980), for instance, rejects those approaches that use "professional dominance" as a justification for the changes of the policies, because the major role in the definition of the social problem is played by the state (Conrad, 1979, p.1). In this sense, Conrad applied a critical stance toward the conventional historical accounts using multi-causal explanatory models of deinstitutionalization. According to the author, in fact, medicine is used "to secure

adherence to social norms" (Conrad, 1979, p.2). Thus, deinstitutionalization is explained as the movement of the function of social control from the psychiatric institutions to the mental health services in the community. In this sense, new medical technology, such as forms of psychotherapies or drugs, but also the extension of psychiatric practices into other fields, e.g. into legal processes or into school, is explained not in terms of medical advancements, but as new forms of social control based on adjustment (Conrad, 1979).

These studies have been subject to numerous criticisms. Rose and Miller (1988), for instance, point out the inability of medicalisation and social control accounts to explain "the development and social vocation of psychiatry and…to comprehend its contemporary operation" (Rose and Miller 1988, p.172). In other words, the use of such all-inclusive concepts is accused of not allowing the description of all the relationships between the different medical branches, but also the rationales and types of regulatory practices, which were developed in the shift from the psychiatric hospitals to community mental health care.

McCubbin (1994), by contrast, criticises economic determinist accounts on deinstitutionalization as they completely reject the human components involved in the transformation and the "mediation of social institutions" (p.36) including families, advocacy groups, professionals and pharmaceutical groups. While Busfield (2000) argues that Scull's analysis applies a wrong periodization of economic fiscal crises, Jones (1972) and Miller (1986) stress the limitations of the use of "madness" as an analytical concept. Although the two authors have used very different approaches, both agree that this concept cannot explain the transformation in psychiatric care, because it was "only a transitory phenomenon" (Miller, 1986, p.14). Scull's analysis can also be criticised because it equalises all critiques of the psychiatric institutions from different centuries and countries, whereas other studies show the historical uniqueness of the British anti-psychiatry argument (Crossley, 1998b). This tendency to generalize the analysis can be associated with the notion of the capitalist economy, too. Although Scull clarifies that his study was about England and America, he often extends his findings to "advanced capitalist societies" (Scull, 1984, p.3). The main feature of Marxist theory, starting the

analysis from a totalizing explanation, such as with reference to the capitalist economic system, makes studies included in this category unable to identify and explain differences in the way deinstitutionalization has been implemented on the national level and consequently unable to make comparisons. Their focus, in fact, rests on the economic system or the dominant class without considering the mechanisms working at the local level.

Governmentality Studies

"Governmentality" is a concept introduced by Foucault during his lectures in 1978 in the attempt to study "the emergence of the governmental apparatuses" (Foucault, 1991, p.96). Rejecting the traditional nominalist conceptualization of the state, Foucault (1991) approaches the study of the formation of government as an ensemble of procedures, strategies and techniques. Thus the state and its institutions are not analysed as a system that adapts to maintain its functionality, but the focus of the analysis becomes the "specific way in which the problem of government is discursively codified" (Rose and Miller, 1992, p.177). Previous categories were purpose-built by me for this research. They were characterised by ensembles of heterogeneous studies, often from different disciplines and traditions, but sharing some similarities in the ways of approaching deinstitutionalization. Studies included in this group, by contrast, share the application of governmentality theories. Specifically, this line of studies has looked at the movement of psychiatric care from the asylum to the community, the formation of mental health care, and the extension of psychiatric knowledge into fields outside the psychiatric hospitals as one of the multiple forms in which the problematic of government has taken shape (Rose and Miller, 1988; Rose, 1985; Castel et al, 1982). While decarceration and social control studies are based on an overarching idea of the state, studies applying this Foucauldian approach reject these totalizing explanations, investigating multiple processes and relations. They also reject any attempt to frame comprehensive and generalizable models to explain deinstitutionalization. Governmentality studies, in fact, aim to explore how specific forms of government emerge in specific contexts.

In order to achieve this aim, these studies examine deinstitutionalization in terms of practices as the visible signs of political projects. For instance, Rose (1985) illustrates the strategies underpinning the Mental Health Act 1983. Challenging the "language of rights" (p.200), Rose (1985) shows the limitation of explaining psychiatric legislation in terms of an opposition between legalism and medical discretion or entitlement, analysing the interrelation of all the main authorities and discourses interacting in the mental health reform in England. Rather than focusing on totalizing explanation, e.g. with reference to the State, political and economic interests, or other agencies, the analysis starts with localized practices, like in the studies conducted on the Tavistock experience by Rose and Miller (1988) and the extension of psychiatric practices into the police in America by Castel et al. (1982). This allows the description of the complexity of the multiple reciprocal relationships between knowledge and political strategies. In other words, the continuity of care, demedicalization/medicalization, the psychological expertise developed during WWII, and the extension of psychiatric practices are analysed as procedures with specific political significance, rather than as causes or consequences of deinstitutionalization or merely as forms of social control and coercion.

Psychiatric practices and legal reforms are not the only subjects of analysis of this productive approach of investigation. Governmentality studies have their strength also in the attention paid to the emergence of knowledge, which is analysed as an ensemble of authorities, theories, techniques, and calculation that has become an element of government itself. For example, Rose (1986) states that "rather than seeking to explain de-institutionalization, we need to account for the proliferation of sites for the practice of psychiatry" (p.83). While previous historical accounts explained deinstitutionalization policies as the result of rational processes or hidden necessities supported by dominant groups, governmentality studies proceed following a bottom-up scheme. In governmentality, the analysis begins with localised practices and proceeds to investigate the connection with organizations, institutions, and other practices in order to illustrate the specific rationalities driving that specific "regime of practices" (Foucault, 1991, p.75). The focus is not just on "how institutions behave, but … also [on] the discursive framework that

renders their practices meaningful through the construction of particular objects (or subjects) of governance" (Joseph, 2010, p.223). Rose, for instance, traces the development of the "discipline of mental health" (Rose, 1986, p.43) during WWI and WWII, showing the reciprocal interconnection between the English political strategies and the rationale of social psychiatry and community treatment, having as the starting point of his analysis the extension of psychiatric practices. Thus, the application of specific psychiatric knowledge is not explained as subject to a specific will or dominant group/class, but as a reciprocal relation between psychiatric discourse and government strategies. According to Rose (1986), while government gave to psychiatry new fields of application in order to address its specific needs, psychiatry gave to government new words and technologies to achieve its aims for the population. This relation between knowledge and forms of government is also reflected in the role played by the researcher in this type of studies. While according to the previous approaches, the author was always external – in assessing the policies or analysing history or as the one who unravels the truth behind power's decisions – this approach challenges the idea of the intellectual as external to the production of knowledge. Accordingly, even calculation and evaluation tools have become a further object of the investigation itself, a further technology of government (Dean, 2010).

It is possible to notice how this approach has tackled the shift of psychiatric care from the hospital to the community in a way very different from the aforementioned approaches. First of all, it does not imply the existence of a perfect model or a standard to be achieved, but it accepts the idea of the existence of multiple forms or strategies of deinstitutionalization. The attention of governmentality studies to all the relations between discourses, rather than their reduction into trends or oppositions, makes this approach suitable to understand all the variations in the multiple changes interacting in the shift from the hospital to community care. In his study on the American psychiatric system, for instance, Castel et al. (1982) explains that this approach enables one "to break with the concept too long prevalent in social control theories and even in some sociologies of mental health, that behind the array of mental health laws, techniques, and

institutions lies one unitary system" (p. xi). This is particularly evident when looking at specific complex assemblages of knowledge, strategies, procedures and technologies which characterise different national contexts (Castel et al., 1982). On the other hand, while Castel et al. (1982) show the potential of this approach in understanding the complexities of deinstitutionalization, there is a lack of attention to comparative analysis. Rather, a tendency to generalise studies made in specific contexts to all western countries is noticeable (Rose and Miller, 1988; Miller, 1986).

This tendency to generalise findings concerning one specific context to all western countries has been one of the main criticisms made of governmentality studies. Zanotti (2013), in fact, has noticed a propensity by some authors applying governmentality theory to adopt "this notion…to theorize the globally oppressive features of international liberalism" (p.289). In other words, while one of the main characteristics of governmentality is the attention on the local and historical specificity of power relations, some applications have let governmentality and liberalism overlap (Zanotti, 2013, p.289). As explained by Lemke (2007, p.44), "Foucault deploys the concept of governmentality as a 'guideline' for a 'genealogy of the modern state' embracing a period from Ancient Greece up until contemporary forms of neo-liberalism". The weakness of those studies applying governmentality in the analysis of deinstitutionalization is that they start with the idea that deinstitutionalization was a common trend among all liberal countries sharing similar discourses, practices, and forms of government. The risk of this is a generalization of local analysis to different contexts. Other criticisms made specifically of Rose's application of governmentality concern his undifferentiated and totalizing readings of power relations. According to Busfield rather than explaining the productivity of power, Rose makes the same mistake that the social control and decarceration models make (2000; 1991), explaining the extension and development of psychological disciplines as technologies of control and the manipulation of individuals.

Governmentality studies provide the most promising approach to deinstitutionalization on the basis of their attention to the multiple rationalities working in the formation of political strategies. The rejection of the definition of a

comprehensive model and of the use of a broad analytical category, such as social control or medicalization, allows for investigations of how local practices and forms of government emerge in relation to specific conditions. On the other hand, the tendency of previous studies on governmentality to generalize their findings to all western countries has limited this approach in its ability to pay sufficient heed to international differences in the implementation of deinstitutionalization.

Conclusion

This chapter has shown the complexity of deinstitutionalization as a subject of study and illustrated the variety of studies on the matter. In particular, four main categories of studies were outlined: deinstitutionalization as a goal, what has been learned from the past, decarceration and social control, and governmentality studies. Table 1 summarises the main aims of these analytical categories, their methodological approaches to deinstitutionalization and their main limitations.

Table 1- Analytical categories of deinstitutionalization summary

	Aim of the studies:	Analytical approach	Limitations:
Deinstitutionalization as a goal	• Assessment of the present implementation of deinstitutionalization policies and services • Definition best practices • Provide suggestions for improvement	• Reality is out there and it is quantifiable, thus deinstitutionalization is studied through variables • Outcomes are mainly quantitative, but new studies are opening to users experiences • Data are compared between different experiences, or on the basis of standards defined by the experts	• Inability to explain deinstitutionalization, because of no attention to processes • Although the attention on cross-national differences, impossibility to explain them • Contrasting results and methods due to the lack of shared definitions and standards
What has been learned from the past	• Construction of a comprehensive explanatory model of deinstitutionalization • Look at historical processes to	• Conventional historiographical approach • History as the product of multiple and observable cause/effect • History as a succession	• Errors in the establishment of cause/effect • Reductionism in the relationships between different ideas based on opposition

	understand present problems	of opposite trends • Social changes, including deinstitutionalization, are observable phenomena	• Tendency to generalise the causes internationally
Decarceration and social control	• Unravel hidden truth • Discover plot from those in control	• Application of critical social theories to the reading of deinstitutionalization • Challenge traditional historical accounts • Looking for hidden and reals causes of deinstitutionalization	• Reductionism in the explanatory model: everything is explained through economy or ideology • Generalization of the analysis among all western countries
Governmentality Studies	• Describe the economy of power (How?) • Outline technologies of government and political rationalities	• Sceptical approach to history • Attention to local strategies • Application of Governmentality as a tool to read the formation of psychiatric practices and mental health systems	• Relapse in new theorizations of social control • Generalization of the analysis among all western countries

The review of the literature has indicated how these different approaches have contributed to the definition of deinstitutionalization from different perspectives. Studies looking at deinstitutionalization as a goal, for instance, have emphasised the difficulty of outlining a shared definition of the concept and illustrate the heterogeneity of the present international policies and implementations, while conventional historical accounts have allowed for the identification of the multiple causes and agencies working on the development of deinstitutionalization and the expectations that motivated these policies. On the other hand, critical approaches, such as Marxist and governmentality studies, have challenged these given assumptions and deterministic relations of causality in the acceptance of deinstitutionalization policies, stressing hidden ideologies and relations between

the formation of knowledge and political strategies. Although previous studies have contributed much to our understanding of the issue and offered multifaceted and contrasting readings of this social phenomenon, the above review has pointed to the inadequacy of these studies to grasp the reasons of national differences in the implementation of deinstitutionalization policies. The aim of this thesis is to extend the comprehension of this subject by filling this gap in knowledge.

The review has also shown that this gap is not due to a lack of interest among other researchers in international differences. It is, rather, the result of the methodological and conceptual limitations of previous accounts. While it was possible to find various cross-national studies on the present implementations of deinstitutionalization, these studies were unable to grasp the processes of formation of these policies and new practices. Studies investigating deinstitutionalization as a goal, in fact, have as their main focus the present implementation of political studies. Moreover, when investigating national differences they approach these in terms of deviations from, or the accomplishment of, a certain standard, rather than focusing on the processes that have led to the implementation of that specific policy. A different limit was identified in the conventional historical accounts: despite the attention paid to the causes, and the attempts to conduct cross-national comparative studies, of deinstitutionalization, these studies have aimed to define generalizable explanations of the psychiatric reform. The result has been the construction of multi-causal models collecting all the causes and agencies interacting in the shift of psychiatric care, but without considering the national historical specificities. While conventional historical accounts tended to flatten national differences, Marxist and social control models have been criticised for their reductionism. Basaglia, for instance, highlights national differences in the implementation of psychiatric policies and practices in Italy and in England, but his explanation is limited to economic reasons without considering any other variable.

The only set of studies showing the potential to illustrate the formation of deinstitutionalization policies in their complexity and differentiation in separate national contexts was that of governmentality studies. Their attention on the

interrelation between knowledge and modes of governing, the rejection of comprehensive and generalizable explicative models, and the focus on local relations of power make this approach more adaptable to grasping the formation of national deinstitutionalizations. On the other hand, this approach shares with the studies driven by Marxist theories the tendency to generalize their results to all western countries. The assumption that deinstitutionalization is the product of capitalism and liberalism reduces the possibility of comparative analysis because it takes for granted that this process was common to all western countries as they share a similar statehood.

In this sense, the review has also shown that the aforementioned inability of previous accounts to analyse differences in the formation of the national deinstitutionalization discourses and implementations is not only methodological but also conceptual. Not just Marxist and governmentalities studies, but all four categories share the idea of deinstitutionalization as an international trend unfolding in western countries. As seen in the brief historical sketch of deinstitutionalization, by contrast, it is possible to notice that the national decisions to change the place of psychiatric care preceded the acceptance and introduction of deinstitutionalization as an "international fact" (Goldman et al., 1982, p.153). On the other hand, none of these studies has considered the formation of this discourse on the national level. Rather, they all have taken for granted the idea of deinstitutionalization as an international process.

In the light of these considerations, this study aims not just to fill the gap in knowledge and understanding of the national differences in deinstitutionalization, but also to overcome the limitations of the previous studies identified during this review. The first turning point that characterises this study, compared with previous approaches, is the rejection of deinstitutionalization as a static concept. In particular, this study challenges the idea of deinstitutionalization as an international event shared by all western countries drawing on the assumption that the formation of the national deinstitutionalization discourses, and its related practices, was strictly intertwined to the specific conditions where it emerged. For this reason, this study has as a main object of analysis the formation and acceptance of

the discourses and practices concerning the movement of psychiatric care in Italy and in England before they were acknowledged as an international trend. Secondly, this study rejects any attempt to outline new definitions or to frame criteria or standards to compare national policies. Nor is it seeking to frame a comprehensive explicative model. In this sense, this research is very different from evaluative and conventional accounts. Rather than looking at deinstitutionalization in relation to the present language and issues, it aims to retrace the moment when deinstitutionalization was one of the multiple possible strategies for psychiatric care. Thus this study aims neither to evaluate the efficacy/effectiveness of the Italian and English implementation nor to check which is the best one. Instead, the aim is to analyse their formations. This study takes a different approach compared to the conventional historiographic stance and Marxist theory and social control. There is, in fact, no expectation to unravel a hidden truth. Nor is deinstitutionalization analysed in terms of positive or negative change. Rather, this study aims to describe the formation of the discourses concerning the movement of psychiatric care and related practices in the specific historical and local contexts under investigation. In this sense, this study shares with governmentality studies some objects of investigation, such as practices on the local levels, and it, as do they, pays attention to the formation of knowledge. On the other hand, it departs from existing studies by focusing its investigation on the formation of the national discourses and practices without proceeding to detail modes of government. In particular, this study is not based on any assumption concerning modalities of government. The attempt is made to approach the object of investigation precluding any established idea of deinstitutionalization. This is so as to retrace how different psychiatric knowledges and practices were accepted in Italy and in England and how these were linked to the implementation of specific national policies and services. My study will offer an original contribution to these existing body of work as it will expand the comprehension of the international differences in the mental health care systems, stressing the role played by the historical national conditions in the formation of the deinstitutionalization discourses and practices.

The next chapter will discuss in more detail these theoretical underpinnings and the methods applied.

CHAPTER III: METHODOLOGICAL CHAPTER

Introduction

In chapter II, the literature concerning deinstitutionalization was reviewed. In particular, it argued that previous studies shared a common feature in their acknowledgement of deinstitutionalization as a fact based on similar underpinning motivations shared by western countries. This study challenges this universal truth claims by stepping back and looking at the national formation of deinstitutionalization discourses. My assumption is that a critical approach to deinstitutionalization can allow a better understanding of national differences in the implementation of policies based on, and open up new ways of examining this social phenomenon. This chapter will illustrate the methodological choices employed to extend the comprehension of international differences in the formation of deinstitutionalization discourses and its related practices.

The first section will justify the selection of Foucault's method, showing how his theoretical framework can overcome the methodological limitations of previous studies and, thus, how this method satisfies the criteria for addressing the knowledge gap identified in the previous chapter. Moreover, it will introduce the main terms of Foucault's theoretical language as applied in this research. The second section will look at my application of Foucault's tools, namely the archaeological and genealogical methods, in more detail, including limitations and difficulties related to their application in cross-national research design.

THEORETICAL STANDPOINTS

As explained in chapter I, the aim of this study is to extend the comprehension of the movement of psychiatric care from hospitals to the community. Specifically, this investigation seeks to illustrate the formation of national discourses that enabled the acceptance of these different psychiatric approaches and practices in Italy and in England. In order to achieve this aim, this research challenges the shared notion of deinstitutionalization as an overarching process involving the main western countries between the 1950s and1970s, examining the formation of this discourse

on the national level. Foucault's tools, namely archaeology and genealogy, are selected and applied as the most suitable devices for pursuing this ambition. As asserted by Kearins and Hooper (2002), "it is difficult to separate Foucault's method from his theorisation" (p.735). Thus, before engaging with the detail of my operationalization of his historical discourse analysis, this section will illustrate how the theoretical underpinnings of his method are consistent with my research questions and enable me to overcome the limitations of the previous approaches as illustrated in chapter II. The emphasis will be placed on outlining Foucault's terminology, as this is one of the most challenging elements in understanding and applying his method. Foucault tended to use common terms with specific meanings (Foucault, 1972). Specifically, this first section will "fix the vocabulary" (Foucault, 1972, p.107) used for this study, explaining the significance of discursive and non-discursive practices, the history of contingency, and critique in Foucault's methods.

The Materiality of Discourse

In one of his numerous interviews, Foucault stated that his first and main project was "the individualization of discourses" (1991, p.54). In *The Archaeology of Knowledge*, Foucault illustrates three possible meanings of the term discourse. The first is the broadest and refers to discourse as a "group of signs" (Foucault, 1972, p.107); a discourse can also be thought of as a "series of propositions" (Foucault, 1972, p.107). In the archaeological method, however, discourse is understood as "the group of statements that belong to a single system of formation" (Foucault, 1972, p.107). Foucault (1972) argues that discourse is a dispersion of elements, and the aim of the archaeological analysis is to retrace the rules that allowed this dispersion to become a unity.

Discourses might be individualised on the basis of the linguistic system they belong to, or on the basis of the subject they share (Foucault, 1991b). As seen in chapter I, Foucault refuses this idea of the unity of the discourse and identifies other criteria for their identification (Foucault, 1991b). Challenging the unity of discourses such as psychiatry, medicine, or biology, Foucault (1991b) looks at their discontinuities in order to retrace the plurality of the discourses included under that socially constructed unity. During an interview, Foucault uses as examples to explain this

discontinuity of discourses: sociology and psychology. He describes them as two "strange entities…which have been continually making fresh starts ever since their inception" (1991b, p.54). The Archaeological method retraces all these "fresh starts", or ruptures in the discourse (see chapter I) with the aim to analyse the specificity of each transformation, as an event in itself (Foucault, 1991b). This process of questioning the unity and retracing the multiple ruptures of the deinstitutionalization discourse will be explained in more detail in the next section of this chapter, in this section I will focus on the materiality of discourse. According to Foucault, the main task of discourse analysis is to identify the "system of dispersion" (1972, p.38) that characterised a specific discourse, and to map its *rules of formation*. These rules are the objects, concepts, and styles of the discourse, but also include their regularities and their conditions of existence, according to which certain discourses are formed, coexist, modified and disappear. Thus, the investigation of the rules of formation means investigating the main elements of the discourse but also the conditions of their appearance and disappearance.

Foucault (1972) places the *statement* at the core of any discourse formation. It is defined as the "atom of the discourse" (p.80). While I will look at this concept in more detail when framing my operationalization in the next section, it is important to stress a specific feature of Foucault's idea of statements and discourses here: their materiality. According to Foucault, statements cannot be reduced to sentences, speeches or texts, but are events in themselves. It follows that discourses are not studied by investigating the structural language or consciousness behind them, but as "sets of discursive events" (Foucault, 1981, p.69). As such, they must be analysed in their material existence and their specific context. In other words, Foucault's discourse analysis deals with specific relations among time, space, subject, and context, which, all together, determine the existence of these statements and the discourses. According to Foucault (1972), because of its materiality, the statement does not need to be clarified. This point is explained by the author using the methodological principles of *reversal*[6] and *exteriority*[7]

(Foucault, 1971). With these, Foucault means that discourses are not created: there is no origin or unique author. Statements are events; they are the result of multiple connections and causes that determine their occurrence.

Clearly, this approach to discourse differs from the approaches applied by previous studies on deinstitutionalization. While the latter have tried to retrace the motivations, conscious activities, or ideologies behind the definition of deinstitutionalization policies, a Foucauldian approach instead leads one to describe "the constitutive rules and [to] position 'the conditions of their realization'" (Gale, 2010, p.387).

This "eventalization" (Foucault, 1991c, p.76) of discourse explains what Foucault means with his expression "discursive practices" (1972, p.33). Discourse is not considered as just language, but as a real occurrence where the rules of formation, the existence, and the disappearance of statements are determined by specific external conditions prevalent in a certain space and at a certain time. Moreover, discursive practices do not work alone but are in continuous interplay with a set of other, non-discursive, practices such as institutions, political practices, technology and economic factors. Foucault (1972), in fact, considers discourses "as practices that systematically form the objects of which they speak" (Foucault, 1972, p.49). In other words, there is a reciprocal relation between discursive and non-discursive practices, as they are both cause and effect of each other. Because of the materiality of the discourse and the strict relation between rules of formation and external conditions, the analysis of discourses cannot be detached by considering other areas of historical analysis (Foucault, 1991c). This attention to the specific historical context of the discourse allows the investigation and comparison of the differences in the formation of national discourses and practices, but also of the individualization of historical transformations within a nation.

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author discipline, will to truth, we must rather recognise the negative activity of the cutting-out and rarefaction of discourse" (Foucault, 1971, pp.21-22).

[7] Principle of exteriority: "Holds that we are not to burrow to the hidden core of discourse, to the heart of the thought or meaning manifested in it; instead, taking the discourse itself, its appearance and its regularity, that we should look for its external conditions of existence, for that which gives rise to the chance series of these events and fixes its limits" (Foucault, 1971, p.22).

The history of the Present

The focus of the Foucauldian method rests on the formation, transformations and disappearance of discourses and practices. It aims to outline "the positivity of discourses, their conditions of existence, the systems which regulate their emergence, functioning and transformation" (Foucault, 1991b, p.69). More specifically, it investigates "how, why and by whom truth is attributed to particular arguments and not to others" (Richardson and Sharp, 2001, p.197). This attention to the processes involved in the formation of the discourses is both at the core of this study and what chiefly distinguishes it from previous approaches to deinstitutionalization. Chapter II illustrated that the history of deinstitutionalization was studied with two main aims: searching for cause-effects and unravelling hidden ideologies and political strategies. The shared assumption of these historiographic approaches was that deinstitutionalization was the solution to a series of problems in western countries, and each study aimed to assess the real causes and expectations of this solution. The application of Foucault's approach to history, by contrast, means taking a step back in order to examine the moment when deinstitutionalization was not yet a solution, but the moment when there were, instead, an unlimited set of possible discourses concerning the management of mental illness. This critical approach to history is based on a specific procedure of investigation that Foucault (1984d) defines as "problematization" (p.49).

This technique implies that the analysis approaches the "transformation of a group of obstacles and difficulties into problems to which the diverse solutions will attempt to produce a response" (Foucault, 1984b, p.389), rather than the formation of different solutions in response to already given problems. In other words, historical analysis is not limited to understanding how, among different solutions to a problem, one was selected. Rather, the investigation takes account of the formation of the problem in itself, resting on the assumption that the solution is implied in the creation of the problem. While previous historiographic investigations took for granted that deinstitutionalization was an international process aimed at addressing problems shared by western countries after WWII,

Foucault's problematization imposes the rejection of deinstitutionalization as a fact and the shift of analytical focus from deinstitutionalization policies to the ways in which the care of psychiatric patients was problematized in Italy and in England before the formation of the international discourse on deinstitutionalization. Thus, even the conception of the problem at the basis of deinstitutionalization is challenged. The focus of the analysis shifts to the formation of the problem itself.

This rejection of the problem as a fact and the focus on problematization are the main features of what Foucault defines as the "history of the present" (Foucault, 1995, p.31). Garland (2014) points out that although this definition "will suggest a form of 'presentism': a kind of historical writing that approaches the past using the concepts and concerns of present" (p.367), Foucault's intention is the exact opposite. Foucault (1984a) argues that "the world of speech and desires has known invasions, struggles, plundering, disguises, ploys" (p.76) and, as such, it is always subject to variations. Thus, this historical investigation aims to retrace these multiple struggles, rather than search for the origin of the problem. While previous historiographic approaches have tried to outline comprehensive models to explain what is now defined as deinstitutionalization, the focus of Foucault's investigation, by contrast, rests on retracing the multiple ruptures and contingencies that enabled the formation and shaping of the unity of the discourse on deinstitutionalization. Foucault defines this approach to history as a search for "descent" (Foucault, 1984a, p.78). This form of examination focuses attention on single occurrences and their specificity with the aim of tracing and maintaining their dispersion, rather than writing another linear history. It follows that events are not explained in terms of continuity. Rather than remaining an illustration of individual big changes, the historical narration becomes a history of multiple contingencies and ruptures. This attention on retracing all the "events in terms of their most unique characteristics" (Foucault, 1991a, p.88) is consistent with the rationale of this study, as each occurrence is supposed to be investigated in the specific context in which it arose. The focus rests on the role of the specific conditions where the event was included.

Paying attention to contingencies and specific contexts, rather than looking for linearity or the definition of a comprehensive model means that Foucault's

approach to history is consistent with this study's aim of retracing national and international variation. Foucault stresses that "as it is wrong to search for descent in an uninterrupted continuity, we should avoid thinking emergence as the final term of a historical development" (1984a, p.83). In this sense, deinstitutionalization cannot be explained as the end point of a process, but is "a place of confrontation" (p.84) between different forces. The emergence of discursive and non-discursive practices is not the result of an unavoidable process, but remains a terrain characterised by continual conflicts, thresholds and disappearances, and, as such, must be studied in this constant transformation. While previous studies have investigated deinstitutionalization as the final result of a series of causes, Foucault's historical investigation, by contrast, allows me to study it a series of multiple events.

To recap, this focus on the local, on the relevance ascribed to the description of every single event, and on attention to multiple thresholds of deinstitutionalization, singles out the archaeological investigation as the most suitable method to address my research questions.

Diagnostician of the present

Foucault's historical method also differs from those of previous accounts of deinstitutionalization in terms of the aim of the method and to the role of the researcher. At different moments in his work, Foucault reflects on his role as a thinker or intellectual and defines his function as a "diagnostician" (Foucault, 2001, p.581) of the present, rather than a philosopher of totality. With this, he refers to two interrelated imperatives at the core of his method: the role of critiques, and the historical consciousness of the researcher. Foucault (1984b, p.385) points out that:

> Criticism is no longer going to be practiced in the search for formal structures with universal value, but rather as a historical investigation into the events that have led us to constitute ourselves and to recognize ourselves as subjects of what we are doing, thinking, saying.

It follows that, first of all, criticism is not an act that is carried out on the basis of universal value. Instead, it is a self-reflection of what we say, think and do. According to Foucault, it is essential to check our "historical awareness of our present circumstance" (1982, p.778) before, and during, our analytical work. In other words, intellectuals should aim to

> On the one hand, open up a realm of historical inquiry and, on the other, put itself to the test of reality, of contemporary reality, both to grasp the points where change is possible and desirable, and to determine the precise form this change should take (Foucault, 1984d, p.46).

This *critical approach* to the reality and the *historical awareness* of the researcher are essential elements of the method of inquiry itself and imply the suspension of the illusion of the objectivity and externality of the enquirer. Foucault (1984c) argues that the quest for truth is not an objective and neutral activity, but intimately related to the will to power of the truth-seeker. It follows that "knowledge is a form of power, a way of presenting one's own values in the guise of scientific disinterestedness" (Poster, 1982, p.119). The production of knowledge is a cutting out (Foucault, 1984b), a definition of what is the truth and what is not. In this sense, history, too, is a way of interpreting and writing reality and what is acceptable. It is a way of controlling and shaping the past. "This means that the historical ontology of ourselves must turn away from all projects that claim to be global or radical" (Foucault, 1984d, p.46). Foucault's method does not aim to frame any universal explanation or comprehensive model. Nor does it look to unravel hidden ideologies. Rather, it aims "to bring some measure of clarity to the consciousness that we have of ourselves and of our past" (Foucault, 1984d, p.45).

Previous accounts of deinstitutionalization have outlined a comprehensive explanation of deinstitutionalization, attempted to uncover hidden ideologies, or searched for standardised criteria to assess its present implementation. By contrast, the application of Foucault's method rejects the possibility of a universal model. Specifically, this method implies that deinstitutionalization should not be approached with pre-established assumptions that consider it as a negative or positive transformation. I will not look at the Italian and the English

implementations in search for the 'best' model, but to challenge what is now taken for granted about this discourse in order to look at it with fresh eyes. Foucault's account also differs from critical accounts which seek to unravel hidden ideologies, for example, decarceration or social control approaches. This is because when Foucault talks about the relation between power and knowledge, he does not refer to an external power imposed on knowledge, as is the case in Marxism, for example. There is no external agency that has the power to control the production and formation of knowledge, nor a hidden ideology. Power is described as a relational force that circulates among discursive and non-discursive practices and hence also in scientific discourses (Foucault, 1984). It follows that, because researchers themselves exist within these regimes of truth, they must be aware of their being part of it in order to disentangle themselves. Foucault's method is thus consistent with the aims of this research, as it does not seek to assess, judge or validate deinstitutionalization as a psychiatric or political strategy, but "is seeking to give new impetus, as far and wide as possible, to the undefined work of freedom" (Foucault, 1984d, pp. 45-46).

This continual critical attitude in the act of research is, I believe, also at the core of Foucault's decision to avoid the definition of any fixed method of inquiry. Foucault provided only a series of imperatives and general guidelines for the application of his method. In particular, applying the archaeological method requires the continual questioning of my methodological choices, including my position in any decisional phase of the research. The next section will illustrate this process of continual re-definition which characterised my operationalization of the archaeological method, from the definition of the analytical stages to the selection of the sources and the modes of presenting my findings.

PUTTING FOUCAULT TO WORK

Although Foucault outlined some general procedures and specific concepts in his works and interviews, e.g. in *The Archaeology of Knowledge* (1972), *Discipline and Punish* (1995), *Questions of Method* (1991), and *The Subject and Power* (1982), he was reluctant to frame his methods in strict guidelines or rules. The result is that

most of the attempts to apply his tools are interpretations (see Hook, 2001; Dean, 1992; Bacchi, 1999) of Foucault's methods. In this research, I have drawn on these authors, but this study mainly applies my own understanding of the procedures outlined by Foucault in his works.

The result of my operationalisation was a two-step process based on archaeology and genealogy. These methods were formalised by Foucault in two different phases of his general work. Although some authors have described them as distinct devices (Jansen, 2008; Koopman and Matza, 2013), I follow those authors who conceive of these methods as a continuum in Foucault's investigations and as the result of his continual reflections on his investigations (Hook, 2001; Dean, 1992). Genealogy and archaeology share the main theoretical underpinnings previously outlined: such as the idea of the contingency of history and the notion of discourse. Although they are characterised by the same objects of analysis, namely statements, they differ in their foci of investigation. This is made explicit by Foucault himself in one of his lectures when talking about the analysis of Abeille's text, he explains that this topic could have been studied either within an archaeology of knowledge, or by applying a genealogy of technologies of power and "reconstruct[ing] the function of [Abeille's] text, not according to the rules of formation of its concepts, but according to its objectives, the strategies that govern it, and the program of political action it proposes" (Foucault, 2009, p.36). It follows that while the archaeological focus is on the rules of formation of the elements of the statements, genealogy shifts attention to strategies and technologies of power. However, Foucault acknowledges the role played by strategies in discourse in *The Archaeology of Knowledge*, explaining the difficulty in outlining them, as "[he] did little more than locate them, and [his] analysis scarcely touched on their formation" (Foucault, 1972, p.65) in his previous works. Foucault frames their analysis synchronously with the elaboration of his theory of power in *Discipline and Punish.* This work marks a shift in Foucault's attention away from the strict analysis of discourse to the analysis of the strategies that enable the acceptance of a particular discourse:

> Archaeology is the method specific to the analysis of local discursivities, and
> genealogy is the tactic which, once it has described these local discursivities,

brings into play the desubjugated knowledges that have been released from them (Foucault, 2003, pp.20-21).

Each discourse, in order to become a unity characterised by its specific rules of formation, is also subject to a set of strategies that enabled its acceptance. The genealogical analysis focuses on these.

Following Foucault's indications in *The Archaeology of Knowledge* (1972), I have identified four levels of analysis: the statement, discursive formation, groupings of discourses and interrelations between discursive and non-discursive practices. While the first three are concerned more strictly with the discourse, the latter level contains the relation between discourses and practices (see Figure 4).

The statement is the starting point of the analysis as the visible and traceable element of the discourse (Foucault, 1972). Thus*, the first step* of the enquiry rests

Figure 4: Levels of analysis
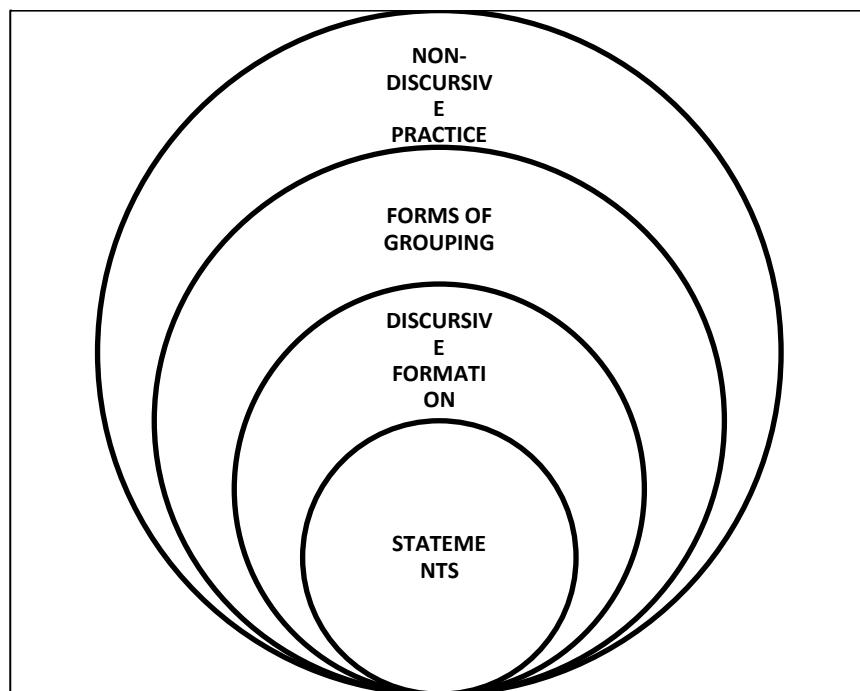
on mapping the "system of dispersion between" (Foucault, 1972, p.38) a number of statements and the regularity between the objects, types of statement, concepts, thematic choices and strategies. The questions that guided the selection of the

statements were: Why do these particular "events"[8] seem important? Why were they being discussed by, for instance, doctors and legal professionals? How do these events differ from before? What are their common features? The focus of the *second analytical level* is the discursive formations. As already asserted, Foucault (1972) defines a discourse as a "group of statements that belongs to a single system of formation" (p.107). In the previous level of analysis, the aim was to map the statements as single events, acknowledging their distinctiveness. This analytical level concerns the relations among the elements of the statements. It questions the connections between their appearance and disappearance, and how their incidence impacts on the discourse of deinstitutionalization in itself.

On *the third level*, Foucault (1972) identifies interactions among diverse discursive formations as the main focus of analysis. In other words, this dimension concerns the relations among different discourses and how they impact one another. Specifically, this level of investigation concerns the interrelations between the psychiatric, legal and political discourses concerning the care of the people affected by mental illness.

Finally, the *fourth level* of investigation explores the link between discursive and non-discursive practices (Foucault, 1972). It is at this moment that the discourses identified at the other levels are related to institutions, policy implementation, services and therapies.

It is important to stress that this division was mainly descriptive, as each moment of the investigation was related to the next. The analysis did not always proceed in a linear fashion, despite the fact that statements remained the central starting point (Foucault, 1972). Each passage, from the definition of unity of discourse to discursive analysis and comparison, was strictly interconnected and contributed to providing a more detailed picture of another level of analysis. This interconnectedness and interchangeability were also reflected during the collection of the documents, as the full research process involved a continual moving back and forth between the different levels and research steps.

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[8] See the eventalization of the statement in the previous section.

Moreover, although Foucault recognized a hierarchy among these levels, this did not determine the importance of the level, but rather the extent of its impact on a specific historical period (Foucault, 1972). In other words, while some historical periods may see important transformations in concepts on the statement level, for instance, the introduction of new concepts, others may be determined by the transformation of relations between the discourses, or transformations in institutions or practices.

The next section will illustrate the different levels of analysis in more detail. Firstly, I will describe the process applied in the selection of the statements and the definition of the positivity of the discourse. Thereafter, I will justify the move to the genealogical method and the main theoretical concepts applied in the analysis of my findings. In order to illustrate each step, I will draw on examples from my study.

Untangling the plot: from the unity of discourse to the definition of statements

The first step of the archaeological analysis was the identification of the statements *qua* "atom of the discourse" (Foucault, 1972, p.80). As seen, statements can take diverse forms, and they are the visible elements of a discourse. This thesis uses documents as the only sources of data. While documentary analysis is acknowledged as an essential part of social research, it is often considered secondary or as an addition to other methods, such as surveys or interviews (Mogalakwe, 2006). Foucault (1972), by contrast, justifies the use of documents as the only form of information in relation to the aforementioned *materiality of the discourse*. Drawing a comparison with archaeologists who reconstruct history through the study of "silent monuments" (Foucault, 1972, p.7), Foucault explains that the archaeological analysis of discourses interrogates documents as *monuments*. The document as a statement is an event and, as such, it must be collected in its materiality, "in the exact specificity of its occurrence" (Foucault, 1972, p.28). It cannot be reduced to text or signification. Foucault points out the risk of reducing a statement to just language or meaning: it is to lose all its distinctiveness as a fact, but also its relations with other statements or events. Thus

this thesis considers documents as real verbalizations of social transformations related to deinstitutionalization and, as such, as primary sources of data.

The statement is the "ultimate, undecomposable element that can be isolated and introduced into a set of relations with other similar elements" (Foucault, 1972, p.80). Following Foucault's indication (1972), I question the unity of discourse on deinstitutionalization to separate it from totalizing history, which describes a shared and univocal process, and detect the "system that governs their [the statements'] division" (Foucault, 1972, p.34).

My analysis starts with historical studies on deinstitutionalization to identify some of the main documents and authorities that contributed to the formation of the present discourse. Some texts coincide with those illustrated in chapter II, for instance Bachrach's works were used for his definition of deinstitutionalization, while Jones (1972), Porter (1991), Guarnieri (1991), and Canosa (1979) were used as historiographic references for the national processes of deinstitutionalization and transformation of psychiatric and legal discourses. These texts were examined with regards to the systems of classification and periodization used by the historians to describe the deinstitutionalization process and the relations with other texts. As seen in chapter II, deinstitutionalization is generally described as an ensemble of policies (Scull, 1984) that determined transformations in the psychiatric and legal settings concerning mental illness (Jones, 1993). On the basis of this broad definition, I divided the unity of the discourse on deinstitutionalization into the legal, psychiatric and policy discourses. Each was characterised by a heterogeneous set of statements:

Legal documents: This group of documents includes laws, acts, penal codes, but also guidelines and papers written by magistrates or legal experts to provide comments or indications on specific laws.

Psychiatric texts: This type of document refers to an assorted ensemble of texts, not all produced by psychiatrists. The majority are produced by professionals and experts working with mental illness and include papers or books aiming at the disclosure of theoretical approaches and methods. This group also includes

assessments and comments on the application of laws concerning the treatment of mental illness made by medical professionals.

Policy documents: This category includes administrative circulars or reports with recommendations produced by committees.

Deinstitutionalization is also illustrated by previous historical accounts as a process involving most of the western countries from the start of the second half of the twentieth century until the present (Killaspy, 2006; Thornicroft, 1989; Fackhoury and Priebe, 2002). Looking in more detail at the historical texts, it was possible to note a further periodization based on two main moments: the rejection of psychiatric hospitals, and the implementation of services in the community. Because it was necessary to compare two European countries in their implementation of deinstitutionalization policies, I added a third moment concerning the strategy of harmonization of deinstitutionalization and psychiatric services by the EU. These periods represented three moments in the formation of the discourse on deinstitutionalization: the first was characterised by the approval of laws concerning the reduction/closure of psychiatric hospitals in Italy and England (beginning of the legal discourse). The second moment represented the real formation of the unity of discourse (deinstitutionalization as an object of study). The third moment saw the acknowledgement of deinstitutionalization as a goal of EU and the WHO (validation of the international political strategy). It follows that the first fragmentation of the unity of discourse on deinstitutionalization was based on the division of the statements related to: the Mental Health Act 1959 in England and L. 180/1978 in Italy, Evaluation studies in the 1980s and 1990s in Italy and in England, and the publication of the EU Green Paper in 2005 (Fig.5). Following the suggestions by Sharp and Richardson (2001) to simplify the management of the large number of documents required by archaeological analysis, I have used these three "critical periods" as a starting point for the collection of the data.

Figure 5- Critical periods

Historical texts provide a reference point not just in terms of periods to explore, but also a context to authors, documents, and political decisions that were deemed more relevant than others by historians. My collection of the statements commenced with laws and policies produced on the national and international level. This decision was based on the fact that they were the most visible signs of the deinstitutionalization discourse, and they were also easy to access and select. Policy documents, national and international reports, and mental health acts are accessible on institutional websites such as www.gov.uk, www.salute.gov.it, www.who.int, and ec.europa.eu in the sections about mental health. Moreover, there are only a limited number of such texts.

The selection of the documents produced by experts from the psychiatric and legal fields, by contrast, was more complex, as the literature on deinstitutionalization and psychiatric care in the community is extensive and multidisciplinary. As this was my first survey between the statements, my aim at this stage was to collect a wide range of texts in an attempt to include all the voices on the topic. On the other hand, I had to construct some criteria for selection. For the *first critical period*, I searched for documents on the first national deinstitutionalization laws in England and Italy. Thus, I collected comments on the acts (L. 180/1978 and the Mental Health Act, 1959) made by various experts. I did not select by the type of author, for instance, authors from the legal, political or medical fields, as the importance of different fields were still subject to investigation: understanding who had the authority to talk about that specific subject was a central element of the analysis. For the *second and third critical periods*, my attention moved to the evaluative studies produced after the implementation of the deinstitutionalization policies in Italy and in England. In particular, I focused on studies evaluating housing services. I

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excluded all documents concerning psychiatric services for children as well as those on the deinstitutionalization of the elderly, people with learning disabilities and physical disabilities. This allowed me to focus on the deinstitutionalization of adult psychiatric patients. While all the technical English documents were easily accessible, the Italian documents proved more difficult, the search departed from papers published in English by Italian authors and moved to Italian documents on the basis of referenced texts. I had access to some of the Italian documents through interlibrary requests, and to others during visits to the Biblioteca Nazionale in Rome.

The aim at this first level of analysis was to retrace the system of dispersion that characterised the deinstitutionalization discourse (Foucault, 1972). Specifically, the main objective was to describe the statements in their respective individuality and specificity, as events themselves. In order to achieve this, Foucault (1991b) identifies three sets of rules that should be used to separate this totalizing history: the rules of formation, threshold and correlation (p.54).

The *rules of formation* refer to the existence of four units that identify statements: the object, a specific style (named "enunciative modality" (Foucault, 1972, p.88), concepts and strategy (Foucault, 1991b). The identification of these rules allows the definition of what it is possible to say or think in a particular discourse, which institutions or experts have the authority to talk about the subject, and what types of style are accepted in that discourse.

The *rules of threshold* or transformation concern the conditions in operation at the moment when the new rules of formation come into effect (Foucault, 1991b). This implies the identification of the historical period when the statement was produced. In this sense, the statement is not investigated alone but is included in the larger historical moment in relation to other statements produced before or simultaneously, with the aim of identifying possible transformations, appearances, or disappearances of any element of the discourse.

Finally, the *rules of correlation* are the set of relations which can be outlined between the discourse under discussion and other types of discourse, and in the non-discursive context (institutions, social relations, economic and political conjunctures) (Foucault, 1991b). This rule is quite extensive and may imply the existence of multiple relations of statements, for instance with other documents, or the use of experts or economic considerations to justify or invalidate its content.

To render this process systematic, each statement was split into the main elements identified by Foucault and included in a table as in the following example (Table 2), which details the Mental Health Act 1959 by illustrating my operationalization of these rules.

Table 2- The elements of the statement

Statement	***Mental Health Act 1959***
Objects	- *Closure long stay hospital* - *Local Authority Services* - *New classification of mental illness* - *Voluntary and compulsory treatments* - *Dissolution of Board of Control* - *Creation of the Mental Health Review Tribunals.* - *Mental Nursing Homes, Residential Homes, Etc.* - *Compulsory Admission to Hospital and Guardianship* - *Admission of Patients Concerned in Criminal Proceedings,* - *Special Hospitals* - *Management Of Property And Affairs Of Patients*
Concepts	*Thresholds: mental health* *Mental disorders: "mental illness, arrested or incomplete development of mind, psychopathic disorder, and any other disorder or disability of mind" (Mental Health Act, 1959, 2).* *Subnormality* *Disappearance: mental defectiveness*

	Transformation: compulsory admission
Style	*Legal and medical*
Strategy	*Medicalization* *Centralization*
Authorities	*Parliament*
Relation	- *Lunacy and Mental Treatment Acts, 1890 to 1930,* - *The Mental Deficiency Acts, 1913 to 1938,* - *National Health Service Act, 1946*
Time, place	*1959- London*

Table 2 shows that the statement was acknowledged as an event in itself, with its objects, concepts, style and strategies, via a site and time when it was published. It also shows the identification of the *rules of thresholds* and *correlations,* which allowed me to build connections with other statements, such as the *National Health Service Act 1946*. These relations led me to the following step.

The selection of the discursive formations and the forms of grouping

After questioning the unity of the discourse, and looked at the system of dispersion of the statements, it was possible to move on to the second part of my investigation concerning the relation between statements (second loop in Fig. 4). This level of inquiry enabled the identification of the series of relations between the main elements of the statements, such as the transformations of the concepts or the disappearance of the objects or the change in the authorities (Foucault, 1972). These relations are retraced both between statements produced in different historical periods in the same country and between statements from the two different countries.

In accordance with my research questions, I started by examining the historical transformations of the main elements of the national discourses in relation to the three critical historical periods previously identified and compared them. I started to list, for instance, the thresholds of concepts in the English legal discourse, such as "mental illness", "psychopathic disorder", and "subnormality", and the rejection of

others, such as "mental defectiveness" after the approval of the Mental Health Act 1959. I also started to compare the use of concepts between the two countries. For example, the concepts of "dangerousness" and "mental health" were central to the English Mental Health Act 1959, but they were absent from the law that marked the beginning of deinstitutionalization in Italy, namely L. 180/1979.

During this analytical stage, it was possible to identify multiple relations among different statements that were previously flattened out by the initial assumption of the unity of the discourse. For instance, previous historical accounts described deinstitutionalization as starting with the approval of the Mental Health Act 1959 and L. 180/1978. Looking at the relations among the statements, I found that the English and Italian documents were related to texts produced before the critical periods identified during the previous analytical stage. I will explain this essential step of my archaeological investigation by referring once to the Mental Health Act 1959 (Table 2). As seen, this English statement was related to preceding documents, such as the Lunacy Act 1890, which was not included in my previous historical division, and, as a consequence, in my first selection of statements. Retracing all these multiple correlations, the initial division into critical periods (Fig. 5) lost its relevance. Thus, my investigation moved back to the first level of analysis. I searched for statements produced before the approval of L. 180/1979 and the Mental Health Act 1959. Moreover, as the focus of my analysis concerned the origin of the deinstitutionalization discourse in Italy and in England, the third period was completely eliminated by the analysis. While during the first statement collection I was obliged to construct some criteria given the high number of statements, the new selection was dictated by the discourses themselves. It followed that the emergence of the English and the Italian discursive formations was characterised by historical periods that were specific to their national conditions.

Figure 6- Ruptures in the national legal discourses

English Legal Discourse - Ruptures

Initial condition: Lunacy Act 1890	First Rupture: Mental Treatment Act 1930	Second Rupture: Mental Health Act 1959

Italian Legal Discourse - Ruptures

Initial condition: Legge 36/1904 Codice Rocco 1930	First Rupture: Legge 431/1968	Second Rupture: Legge 180/1978
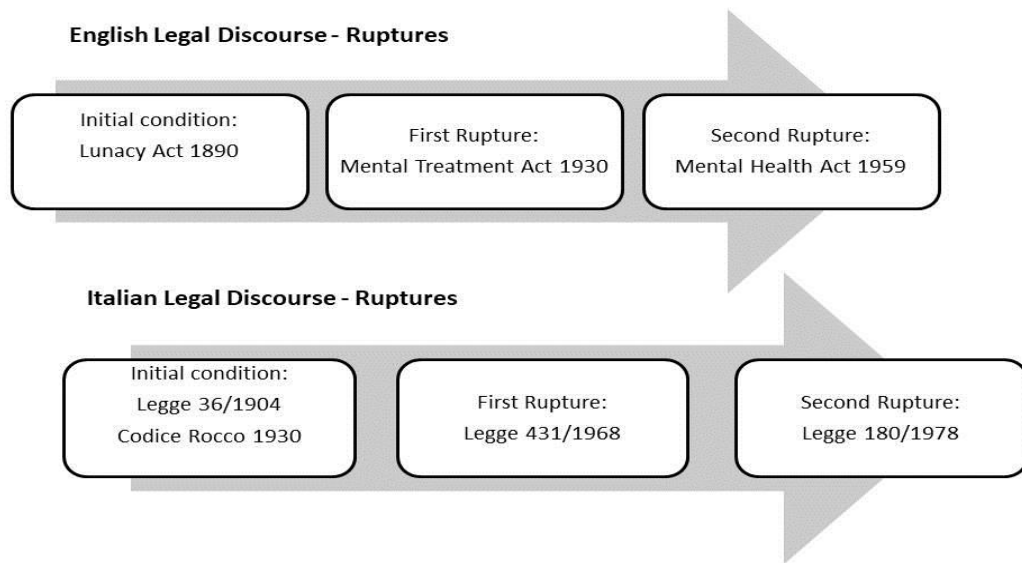
The difference was not only detected between the emergences of the discursive formations in the two countries, but also between the different discourses under analysis, namely the legal, the psychiatric and the policy discourses. Although these were related on the national level, their occurrences were slightly different.

Figure 6 illustrates by way of example the case of the formation of the legal discourses in Italy and in England. This periodization is different from the one outlined at the beginning of the study (Fig. 5).

The archaeological analysis thus allowed me to break the unity of the deinstitutionalization discourse in the legal, psychiatric and policy discourses, and then on the national level. I was able to retrace the emergence of deinstitutionalization in relation to each of these discourses. At this stage, I was working with six different discourses, three for each country, characterised by very different historical ruptures and types of documents. If, on the one hand, I have tried to preserve their distinctiveness in order to keep my analysis systematic, on the other the *third analytical level* and my research questions required me to check the relations between these discourses within and between the countries. Because of the complexity of the multiple relations among these discourses in presenting my findings I retain the divisions between the countries and between the psychiatric (chapter IV) and legal discourses (chapter V).

The end of the collection of the data corresponded with the saturation of all the rules of the existence of the discourses under analysis. Although Foucault does not provide an explicit limit to data collection, this was, to a certain extent, driven by the discourse itself. Thus it was like following a limited number of paths clearly signposted and characterised by different scenarios and distances. The result of this methodical collection, recollection and selection of specific statements as events is defined by Foucault as the "archive" (1972, p.126). It is important to emphasise that by this term, he does not refer to a corpus of scripts collected in a certain period of time, but a "set of rules" (Foucault, 1972, p.57) which, at a given period and for a given society, defines "the limits and forms of the *sayable*…, of *conservation*…, of *memory* as it appears in different discursive formations…, of *reactivation…of appropriation*" (Foucault, 1991b, pp.59-60). In other words, the main intention of archaeology is the depiction of an archive in which the rules that describe the "fact and conditions of their [discourses] manifest appearance" (Foucault, 1991b, p.60) are listed. The definition of the archive coincides with the tracing of the historical *a priori*[9] of a period, in other words, the moment when the unity of the discourse has been established (Foucault, 1972). The initial intention of this project was to limit the analysis to the definition of this high level of productivity and dispersion of the statement. My aim was to carry out an archaeological analysis of the psychiatric and policy documents on deinstitutionalization and to keep the comparison between Italy and England on the level of discursive formation without entering into detail on the fourth level of analysis concerning non-discursive practices and strategies. However, the relations between the different national psychiatric discourses and the inextricable links between the national psychiatric and legal discourses on deinstitutionalization and the re-organization of mental health governance in the two countries made this impossible. The national economies of power related to the formation of

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[9] Foucault distinguishes between the formal *a priori* and the historical *a priori*. "The *a priori* of positivities is not only the system of a temporal dispersion; it is itself a transformable group. Opposed to formal *a prioris* whose jurisdiction extends without contingence, there is a purely empirical figure…The formal *a priori* and the historical *a priori* neither belong to the same level nor share the same nature." (Foucault, 1972, pp.127-128)

psychiatric knowledges and the implementation of the deinstitutionalization policies turned out to be indissoluble. In the next section, I will justify this theoretical decision to examine non-discursive practices and strategies. In order to achieve this, the following section differs slightly as it focuses on the main theoretical concepts applied to analyse the data during the genealogical moment, rather than explaining the pragmatic steps of data collection.

Strategies and genealogy

In *The Archaeology of Knowledge*, Foucault (1972, p.64) defines strategies as:

Ways of treating objects of discourse…of arranging forms of enunciation…of manipulating concepts…These options are not seeds of discourse… they are regulated ways…of practising the possibilities of discourse.

Strategies are part of the discourse, but they are different from objects, concepts, and styles, as they organise them in a systematic and specific way; they can delimit, regroup and select the elements of statements according to urgent or necessary needs (Foucault, 1995). For this reason, Foucault ascribes them a special function and location: strategies define the relations between the elements of the statement and the context. They rest on a level between discursive and non-discursive formation. Foucault (1972) explains that until *The Archaeology of Knowledge*, this level of analysis was still in a phase of elaboration. The analysis of strategies then became the central element in his work from *Discipline and Punish* together with the introduction of his theory of power. He describes this specific type of analysis as:

A genealogy of the present scientific-legal complex from which the power to punish derives its bases, justifications and rules, from which it extends its effects and by which it masks its exorbitant singularity (Foucault, 1995, p.23).

With the introduction of the genealogical level of analysis, Foucault opened up a particular way to study power in relation to modes of subjection and the formation of knowledge (Foucault, 1995). While in archaeological analysis the focus rests on discourse and statements with the aim of retracing the historical a priori (the level of positivity of the discourse), in genealogy, the focus moves to the fourth level of analysis (Fig. 4), which investigates the correlations between discursive and non-discursive practices (such as institutions, economy, therapies, evaluative tools and so on). Specifically, in my study, I found it necessary to look at the interrelations between the transformation of the national legal and psychiatric discourses concerning mental illness, and the re-organization of the Italian and English ways of governing mental illness and health, in conjunction with the establishment of the deinstitutionalization discourse.

As previously asserted, my initial aim was to investigate the transformation of the main elements of the discourse (e.g. concepts, objects and style) during the shift of psychiatric care from the hospital to the community in Italy and in England, and to compare the national discourses. While looking at the rules of *thresholds* and *correlation* in the statements, however, it became apparent that the national psychiatric and legal discourses were inextricably entangled with the birth of national public health systems and welfare states. This correlation has been acknowledged and investigated by other studies, in particular those on governmentality, yet these approaches assume the existence of a common style of government among western countries that has led to the implementation of deinstitutionalization policies (see chapter II). The discrepancies identified in the national legal and psychiatric discourses during the archaeological investigation, by contrast, allowed the identification of the correlation of these discourses with nationally specific modes of government, stressing their differences. The decision to include the genealogical level of analysis in the research flowed from the fact that I found these findings very relevant to my research questions, and, as constituting, an important contribution to knowledge on deinstitutionalization.

Although discourse remains at the centre of the analysis, at the genealogical level attention is trained on the power relations between discourses and practices. While

archaeological analysis starts from the unity of the discourse, the genealogical analysis uses "resistance as a chemical catalyst so as to bring to light power relations, locate their position, and find out their point of application and the methods used" (Foucault, 1982, p.780). In other words, Foucault directs us to account for strategies in terms of struggle, rather than as forms of rationalities driven by some kind of agency. All struggles are characterised by a form of resistance to a corresponding type of power, thus, their identification allows us to locate power relations (Foucault, 1982). At the basis of this analysis of power is Foucault's particular conception of power as a positive force. Strategies are described by Foucault as war tactics: any form of resistance needs to organise itself to fight and this implies the formation of theory and practices. Using this frame, the formation of psychiatry (theory and practices) outside the psychiatric hospital is read as the result of a struggle against a particular form of power, characterised by a specific psychiatric discourse and practices in the hospital. The genealogical level of analysis is the detailed investigation of the relation between the formation of knowledge and practices resulting from these struggles on the local level.

Starting from the historical *a priori* identified during the archaeological analysis, in this moment of the research my attention moved on to the identification of the struggles that enabled the formation of certain discourses on the national levels, and the places where they developed. What I was questioning were the institutions in which these struggles started, the subjects involved, the function of the discourses outlined in the previous level in relation to these institutions, the types of practices developed during these struggles, and the specific needs at the basis of them. The result was a map of the practices and institutions that appear, and disappear, in relation to the development of the deinstitutionalization discourses in Italy and in England.

Cross-national design and the archaeological method: an analytical challenge

As described in the introductory chapter, the decision to compare the Italian and English psychiatric systems was triggered by my personal working experience. The first part of this chapter demonstrated that one feature of the archaeological

method is to search for ruptures, contingencies and differences, rather than commonalities and trends. The application of a cross-national design aims to reinforce this element of the archaeological method. The role of cross-national research in sociology as a valuable analytical strategy for taking into account differences and inconsistencies that cannot be uncovered in single-nation research has already been acknowledged (Kohn, 1987; Hantrais & Mangen, 1996).

The decision to apply a cross-national design to the archaeological investigation and to focus on two cases was justified by both theoretical and pragmatic reasons. Italy and England are two relevant examples to compare, as both implemented deinstitutionalization policies before this was defined as an international trend. In other words, they were among the first western countries to implement this shift. Moreover, they are two outliers and distinctive cases, as England was the first country to approve a deinstitutionalization law (WHO, 1951), while Italy was the last, but did so with a very radical reform (Bennett, 1985). In addition, these two countries are characterised by very different political (Esping-Andersen, 1990), legal and psychiatric systems (Jones, 1996; 2000), as well as historical trajectories (Goodwin, 1997), allowing the analysis to stress the differences. This means that findings can be argued to be more robust despite the low number of cases. The decision to consider England, rather than the whole of the United Kingdom, is related to the fact that Ireland, Scotland and Wales are characterised by very different histories of psychiatric care and different policies (Bartlett and Wright, 1999). To consider the other parts of the United Kingdom would have required adding a further three cases to the comparative study. The central reason for the focus on two cases was the feasibility of applying my method properly. Despite the productiveness of applying a cross-national research design to a very detailed discourse analysis, these advantages come at a price. The most difficult part of applying Foucault's method was the *management of a large number of documents* from different sources and historical periods and in different languages.

Foucault (1984a) defines his method as "gray, meticulous, and patiently documentary" (p.76), and in cross-national design, this meticulous documentary work is multiplied by the number of countries under investigation. As illustrated,

archaeological investigation is characterised by a continual movement back and forth to search for statements until the complete saturation of the documents that formed the discourse has been reached. This implies that an *a priori* definition of selection criteria is impossible. The definition of *the archive* requires a continual process of selection of documents. Thus, during the analysis, the only way to control this extensive collection of documents is to apply a very systematic approach to the texts. It is essential to schedule every statement proceeding step by step, keeping primary sources divided on the basis of their discourse, authority, historical period and country. As explained, this methical division was retained during the presentation of my findings, in order to simplify the reading, but also represents my analytical process. This difficulty in the management of documents was due not only to the large number of the texts but also to their heterogeneity. In particular, this was problematic for the presentation and referencing of legal documents, as the Italian and English legislative systems are quite different.

A further issue when applying a cross-national design to discourse analysis which justifies the choice to limit my comparison to Italy and England relates to *translation.* As pointed out by Kohn (1987) in his paper on cross-national studies, "the most fundamental methodological issue is whether the concepts employed in the analyses are truly equivalent" (p.720). In a comparative discourse analysis between different countries, this element occupies a central position. The majority of the documents used as primary sources for the investigation of the Italian discourse formation were written in Italian. They are analysed in their original version and translated for the presentation of my findings in this thesis. Yet translation cannot be "a mechanical reproduction" (Zongxin, 2003, p.47). It requires my interpretation to make a specific concept *equivalent* to a foreign reader. As explained by Zongxin (2003),

> Communication involving translation is more complex than intralingual communication. Procedurally, the author's message does not go directly to the target-language reader. It goes by way of a translator who acts both as a reader and a re-writer (Zongxin, 2003, p.47).

I have restricted my case studies to Italy and England because it is essential to have equal knowledge of the language and the cultural and psychiatric contexts in order to maintain the specific meaning of the text.

Conclusion

This chapter offered an overview of my operationalization of Foucault's archaeological method. It provided a description of the main sources of data used in this study and outlined some of the main difficulties of applying the archaeological discourse analysis to a cross-national design. More specifically, it also shows how this method differs from previous approaches to deinstitutionalization in order to provide a fresh perspective on the subject.

The chapter described how the application of a cross-national comparative archaeological analysis can allow one to emphasise differences and contingencies in the Italian and English discourses, rather than outlining a general theory or a comprehensive explanatory model of deinstitutionalization. This shift away from the identification of trends and commonalities enables one to explore the differences in the conditions where the national discourses on deinstitutionalization formed. Moreover, rejecting the notion of ideology as an analytical category for explaining social change, and placing the visible elements of the discourse and the conditions of their emergence at the centre of the investigation, this method was deemed the most suitable for addressing my research questions.

The following chapters will illustrate the findings of this cross-national archaeological study of deinstitutionalization discourses in England and Italy.

CHAPTER IV: THE TRANSFORMATION OF PSYCHIATRIC KNOWLEDGE IN ENGLAND AND IN ITALY

Introduction

The emergence of the discourse concerning the care of psychiatric patients in the community was related to two main social and political events: changes in psychiatry and the disciplines related to mental illness and the creation of community-based services. Those events are represented in literature as a strong rupture with the past when the hospital was the only place where people with mental illness were treated and psychiatry was practised (Scull, 1984; Jones, 1993). From a certain moment in history, the centrality of the psychiatric hospital, as the exclusive place of psychiatric practices and object of the laws concerning mental illness, changed. These shifts were related to important transformations in psychiatric knowledge and practices. This chapter will focus on the origins of these new psychiatric discourses in England and in Italy.

It is important to stress that this chapter is not aiming to write yet another history of psychiatry, based on progress (Jones, 1972; Kritsotaki et al., 2016; Turner, 2004), but it will outline the set of social and historical conditions that made possible the formation, and acceptance, of these new psychiatric discourses in England and in Italy. In order to achieve this, the idea shared by previous studies on deinstitutionalization (see chapter II), linking this shift in the care of mental illness to a common transformation of psychiatric knowledge and practices involving all the western European countries, will be challenged. As illustrated in chapter III, the assumption of my work, by contrast, is that knowledge is not merely a result of discoveries, but a social phenomenon, and, as such, inextricably related to relations of power (Foucault, 1995). This does not imply that psychiatric knowledge, and its practices, were just used by specific dominant groups, as a technique of control of deviance, but that power and knowledge are related in a reciprocal manner. According to Foucault (1995), in fact, "power produces knowledge…there is no existence of a field of knowledge without a relation of power" (p.27), but there is

no knowledge that does not imply and, at the same time, constitute relations of power. There is a strict relation between an apparatus of power and the truth discourse related to it. Thus, there is no one absolute knowledge and there is no one truth, as they are linked to the economy of power in which they are included. On the basis of this, the formation of these new psychiatric discourses involved in deinstitutionalization will be explained in terms of strategies, constraints, and struggles that were strictly related to the national historical context.

The first section of this chapter will explore the conditions that enabled the formation of the English social psychiatric discourse, emphasising particularly those that enabled, at first, the problematization of a medical approach to mental illness and the psychiatric hospital, and after the validation of its practices. The second section will outline the origin of the Italian psychiatric reform, stressing the main differences between the births of the two national discourses. In particular, the last subsection will be dedicated to the comparison of the Italian psychiatric discourse with the English anti-psychiatric one.

THE BIRTH OF THE SOCIAL PSYCHIATRIC DISCOURSE IN ENGLAND

War neuroses: the call for psychiatric expertise

According to a paper about Psychiatry in England published in 1955, "less than 50 years ago…psychiatry, as we understand it today, was not yet born" (Odlum, 1955, p.47). This section will describe the origin of this different psychiatric discourse, which was related to the acceptance of psychiatric care into the community in England. In particular, it will outline the ruptures (Table 3) in the English psychiatric discourse that allowed the problematization of the previous medical approach to mental illness, the recognition of psychological and social causes of mental illness, and the extension of the psychiatric practices outside of the hospitals, before the approval of the Mental Health Act in 1959. To highlight this briefly, from here on, this thesis uses the word "rupture", not with the strong connotation of the traditional historical accounts, but to refer to the discontinuities of the discourse (see chapter I).

In order to outline the formation of the main objects of this new psychiatric discourse and practices in more detail, it is important to illustrate the conditions that enabled this change. The origin of the transformation of the English psychiatric discourse can be traced in the army during WWI. The "urgent need" (Foucault, 1980, p.195) derived by the war required a great availability of soldiers and medical staff that were recruited "for the efficient carrying on of the war" (Anonymous, 1915, p.1421). Medical expertise was applied for the "developments of military surgery" (Anonymous, 1915, p.1417), in order to reduce the impact of epidemics and to treat soldiers in place without leaving the front. Moreover, when the British government ratified the conscription with the approval of the National Army Act in 1916, medical knowledge was also required for the "medical examination of men of military age" (Ministry of National Service, 1919)[10].

Table 3- Ruptures in the English psychiatric discourse

RUPTURES in the formation of the English social psychiatry discourse	Problematization of medical psychiatry: War neuroses studies:
	Officialization: Army report on Shell-shock
	New practices: -Test -Group therapy -Therapeutic Community

Among the various diseases affecting the soldiers on the front-line, mental diseases became a central object of medical debates since the beginning of WWI, and "the development of hysteria, neurasthenia, traumatic psychoneuroses, and so on" was equated to the risk of "cholera in camps" (Anonymous, 1914, p.1388). For this reason, experts on mental illness were called to study the phenomenon, as illustrated by the following quote:

Data furnished already by four months' war suggest that…an opportunity has arisen for the reinvestigation of these vital problems of nervous and mental disease" (Anonymous, 1914, p.1388).

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[10] The approval of the Military Service Act in 1916 ratified the conscription for all man from 18 to 41 in health conditions and not married.

War was presented as an "opportunity" (Anonymous, 1914, p.1388) to study the origin of mental illness because of the "connexion between the stress and strain of the war and the development of hysteria" (Anonymous, 1914, p.1388), and this attention was even boosted by the use of new explosive arms. In 1915, a new mental disorder, specific of the war context, was introduced in the medical discourse. Three cases of soldiers affected by similar symptoms were reported in great details in The Lancet, acknowledging "a definite class [of symptoms] among others arising from the effects of shell-shock" (p.320), and characterised by a "close relation [to]…'hysteria'" (Myers, 1915, p.320). Between 1916-1919, war neuroses[11] became a central object of observations, treatments and studies (Myers 1915,1919; Hurst, 1917; Wiltshire, 1916; Mott, 1917a) for the medical staff in the army. According to Myers, "no medical officers have felt the strain of war more severely than those engaged in the treatment of functional nervous disorders" (1919, p.51). Although there was a general agreement that "the functional nervous affections of modern warfare [were] essentially the same as the functional nervous affections of civil life" (Wiltshire, 1916, p.1207), the main object of the debate was related to the aetiology of the syndrome. Wiltshire (1916), for instance, acknowledged five main causes in this dispute: "1. Wounds. 2. Possible physical causes…3. Possible chemical causes… 4. Possible psychic causes…5. Causes of relapse" (p.1208). The experts' debate was split between those looking at war conditions as the cause of specific forms of hysteria, such as shell-shock, while others stressed the importance of psychic causes associated to predisposition and the history of the patient. These approaches were characterised by very different theoretical stances, and methods. While the former favoured medical observation, the latter applied psychological theories and methods of investigation. In terms of discourse formation, this debate was relevant not because of the validity of one hypothesis, rather than another, or for the discovery of a new illness, but because this period was characterised by a strong productivity. In other words, war needs created the conditions that enabled

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[11] The term here is used including all the names used by the different papers concerning functional nervous disorders during the years of the war.

a rupture in the previous discourse on mental illness, and the thresholds and transformations of multiple elements in the English psychiatric discourse.

This debate did not stop during the war, and it was not limited to the administration of medical treatments and hospitalization of soldiers, but it involved also their punishment[12] and the delivery of pensions. While for other pathologies, it was possible to identify the physical cause in the body; cases of war neuroses were difficult to differentiate from malingering, or other mental illnesses:

> As regards these conditions in relation to the war, pensions, and so forth, much harm has resulted from confusion between the three classes of cases…(1) cases of pure neurasthenia due to overwork or worry; (2) hysteria following shock, i. e. the so-called 'shell shock'; (3) hysteria combined with malingering, the gain sought for being either exemption from military service or a pension. Besides these there are, of course, cases of pure malingering (Lumsden, 1916, p.862).

In other words, war neuroses affected, at first, the economy of the army during the war because of manpower, and soon after the public economy. The first report on the distribution of pensions, in fact, emphasised the effect on pensions' allocation due to the difficulty of doctors in the pension committee to re-examine ex-soldiers affected by shell-shock. According to the witnesses from the committee, the main issue in evaluating neurotic cases was that the Workmen's Compensation Act dealt with "actual physical damage" (Select Committee on Pensions, 1919, p.173), while shell-shock, not having physical causes, were "awfully difficult cases to estimate" (Select Committee on Pensions, 1919, p.173).

War neuroses became a very expensive issue, and, as such, they were problematized not only on the medical level but also on the governmental one. After the war, a commission was required to investigate how shell-shock cases were managed during the war. The war office committee was split into three

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[12] If a soldier was diagnosed with shell-shock, he was supposed to be hospitalised or sent home with a pension as any other injured soldiers. On the other hand, if he was defined as a malingerer, he would be court-martialled and punished with death penalty.

commissions: "(a) Treatment of patients. (b) Enlistment and observation of the recruit. (c) Training and courts-martial" (War Office Committee [WOC], 1922, p.7). While the first two were related to medical knowledge; the third one was specific to the army organization. The increase in the cases of nervous disorders among the soldiers was explained by the report as due to two main interrelated factors: the lack of specific training of the medical officers, and the use of the term shell-shock. The former impacted on the number of cases, as medical officers, without a previous experience with mental disorders, classified different conditions under the same diagnosis: "as regards the officially recorded cases of 'shell-shock', there could be little doubt that included under this heading there were cases of many and various conditions" (WOC, 1922, p.6). Medical methods based on the observation of the body, which was predominantly applied for the diagnoses of mental illness until WWI, resulted inefficient in the distinction between malingering, and war neuroses. This impacted also on the disciplinary system applied by the army as malingering and desertion were punished through death. The inability of medical knowledge to establish "how far [soldier's] behaviour appears to be voluntary or involuntary" (WOC, 1922, p.141) made the application of punishment by death very difficult. In addition, the report stated that medical difficulties were also exacerbated by the "popular use of the term shell-shock" (WOC, 1922, p.6). According to the WOC (1922), "to the public mind any condition, which arose during the war, and that gave rise to the assumption of irresponsibility of conduct by the individual concerned was to be ascribed to shell-shock" (p.6). This was explained as shell-shock "became a most desirable complaint from which to suffer" (p.6) compared to mental illness, or cowardice. In this sense, punishment by death, as a disciplinary measure, was considered inefficient also for a second reason. With an increased number of soldiers suffering from war neuroses, the application of death punishment would have increased the number of losses, in a moment when there was also an increased need for manpower. On the basis of this inquiry, and "many witnesses of high authoritative standing" (WOC, 1922, p.129) collected by the committee, the report defined shell-shock as a "misleading" diagnosis (WOC, 1922, p.7), and recommended the complete disuse of the term. This rejection of

the term shell-shock, which clearly stressed the external causes of war neuroses, worked as a filter among the different experts' voices as it shifted the object of study from the effect of explosions to other causes, namely the psychological one. In this sense, the transformation of the English psychiatric discourse cannot be reduced to medical discovery, or to an epistemological controversy, but it was strictly related to specific needs related to the management of the soldiers in the army. In other words, shell-shock, as a mental disease, was problematized not only because it challenged medical knowledge, but primarily, because it tested the efficiency of the full British army, and the pension system.

The report did not impact only on the theoretical discourse on mental illness, but also on the function played by psychiatry, and its settings. In order to solve this flaw in the army disciplinary system, the War Office Committee (1922) recommended the introduction of specific expertise and training on mental disease for the medical officer:

> We are strongly of the opinion that the treatment of the psychoneuroses can only be satisfactorily undertaken by those medical officers who have received special training in the subject…An adequate course should include instruction in (1) Psychology; (2) Neurology; (3) Psychiatry; (4) Psychopathology, including the nature and treatment of the various types of psychoneurosis, and the doctrines and relationships of the various schools of thought. (5) Clinical instruction (pp.189-190).

The report acknowledged the importance of psychiatric and psychological training among medical officers, enabling the acceptance of the application of psychiatric knowledge outside of the hospital's walls. Thus, it is essential to emphasise again that the movement of psychiatrists from the hospitals to a different setting was not due to a new medical discovery, but to a problem of efficiency in another disciplinary institution (Foucault, 1995). As will explained in more detail in the next subsection, psychiatry and psychological expertise were called to improve the efficiency of the disciplinary machinery of the Army in order to avoid a future new epidemic of war neuroses among soldiers. This process of *externalization* of

psychiatric knowledge and practices was completely implemented during WWII, as illustrated by Rees (1943),

> Early in 1940 specialists in psychological medicine were appointed to each command in this country…Gradually more psychiatrists were added, either full specialists with the rank of major or 'graded' specialists…After the first eighteen months of the war it was becoming increasingly obvious that administrative procedures were fully as important as clinical or purely professional questions in Army psychiatry, and eventually early in 1942 a Directorate of Army Psychiatry was set up as part of the Army Medical Services (pp.1-3).

The two world wars played a central role in the process of institutionalisation of psychiatry in a context different from the psychiatric hospital. This process was not limited to the movement of psychiatry from an institution to another, but it was linked to the acceptance, rejection and creation of various elements in the English psychiatric knowledge, as well as the creation of new practices. The next two subsections will look at some of the main objects and practices that were at the heart of the English social psychiatric discourse.

The birth of social psychiatry and the problematization of the psychiatric hospital

The previous subsection illustrated how the inquiry on shell-shock, rejecting the hypothesis of a specific external trigger to hysteria, such as explosions, enabled the acceptance of a psychological approach to mental disease. The report was not limited to make recommendations concerning the future application of psychiatric knowledge in the army, but it supported them using studies and theories made by various experts. Looking at the origins of the shell-shock syndrome, the War Office Committee (1922) dedicated two sections on the history of "Shell shock and neurosis in former wars" (p.8), and another on the "References to neurosis in classical literature" (p.10). The historical background was used to give validity to the phenomenon by searching for previous cases in the literature. The document was also characterised by the use of very specialised terminology and it stressed that

most of the "evidence given by witnesses" came from the "service medical authorities and the medical profession from the experience of the war" (WOC, 1922, pp.12-13), thus, the most authoritative experts in the field. The WOC (1922) even made reference to specific studies, as in the following quote: "for full account of these investigations vide 'War Neuroses and Shell Shock: Mott, 1919'" (p.103). To a certain extent, the report was not only a call to extend the medical knowledge in the army, but experts were also used to justify the strategy proposed by the committee itself. While from one side, the army report validated a different approach to mental illness, on the other side, experts, and their knowledge, were used by the government in order to give evidence of the problem, and their strategy. This reciprocal relation between experts and official documents was a central element in the acceptance of the deinstitutionalization discourse in England, and it will be discussed in the following chapters. The use of this authoritative context enabled the validation of some central objects of the new English psychiatric discourse, such as emotions, and a different representation of the psychiatric patient. This subsection will look at the acceptance of these objects in the psychiatric discourse, and the formation of social psychiatry in relation to the problematization of psychiatric hospitals as a place for the care of psychiatric patients.

Emotional shock, and its effects on the body, were not new objects in the psychiatric discourse before WWI, as stated in this quote: "the nervous effects of intense emotional strain involving the risk of death first received medical recognition in 1875" (Forsyth, 1915, p.1399). On the other hand, their effects were generally considered secondary in neuroses, as in the hypothesis of "commotional disturbance"[13] (WOC, 1922, p.14), or even rejected as a direct cause of mental diseases:

> The question of the influence of emotion in the development of hysteria has often been discussed. M. Babinski, it will be remembered, holds that hysteria never originates in emotion and instances in support of his views the absence

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[13]"Commotional" was used to describe those illnesses resulting from a mix of physical and emotional causes.

of hysteria after the severe mental strain produced in the inhabitants who suffered from the earthquakes at Messina (Anonymous, 1914, p.1388).

The report produced by the WOC (1922) allowed the complete recognition of the effect of "emotional disturbance" (p.4) on the body. The aforementioned highly specialised discourse of the report, in which these objects were included, reinforced their own validity and credibility, and enabled the acknowledgement of "mental stress" and "mental terror" as the "most potent" (WOC, 1922, p.31) causes of war neuroses, even more than the effect of bombs and explosions.

The acceptance of emotions, especially "fear" (Mott, 1917b, p.39), as the main cause of war neuroses, was related to important transformations in the methods of investigation applied by psychiatry, such as the study of the content of dreams. Soldiers sleeping were not a new object of medical inquiry[14], but the observation of the body asleep was substituted with "the psychology of soldiers' dreams" (Mott, 1918, p.169), as "a general and very distressing symptom of war neurosis"(WOC, 1922, p.10). The WOC (1922) validated the use of the "theory of repression" (p.96) to explain the terrifying dreams of soldiers. According to this approach partially drawing on psychoanalysis[15], shell-shock was caused by the unconscious attempt of a soldier "to suppress his painful experiences and dissociate them from the general body of consciousness" (WOC, 1922, p.96), and dreams were the evident sign of a psychic "natural defensive reaction" (WOC, 1922, p.96). The acknowledgement of this approach to neuroses enabled the reconsideration of the validity of psychoanalytical theories and approaches based on emotional disclosure, which were previously completely undervalued by the British psychiatric context. Previous medical procedures for the treatment of shell-shock, in fact, favoured the silence and the rejection of any thought related to warfare experiences (Rivers, 1917). After the Inquiry on shell-shock, talking about emotions, and wartime painful

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[14] See Myers, 1919 in The lancet: A final contribution the study of shell shock. Being a consideration of unsettled points needing investigation.

[15] See Mott paper refers to Freud. Although he agrees in the importance given to the dreams, he does not agree with Freud's interpretation of dreams linked only to sexual life.

experiences, was acknowledged as an essential element for the treatment, or at least the relief, of the symptoms of war neuroses:

> We talked about his war experiences and his anxieties, and following this he had the best night he had had for five months. During the following week he had a good deal of difficulty in sleeping, but his sleeplessness no longer had the painful and distressing quality which had been previously given to it by the intrusion of painful thoughts of warfare (Rivers, 1917, p.5)

The inclusion of emotions in the psychiatric discourse shifted the representation of mental illness from being an illness of the *body* to an illness of the *soul*. Medical professionals treating soldiers affected by neuroses "lay stress upon the terrible experiences through which the sufferers have passed" (Anonymous, 1916, p.627). In this sense, the soldier affected by neuroses was depicted as a physically healthy man, who experienced very painful experiences that affected his emotional state.

The space given to the emotional conditions of the soldiers allowed also the problematization of the representation of the individual affected by mental conditions, such as neuroses, and "the unsatisfactory and inadequate nature of existing methods for dealing with the mentally alienated among civilian patients" (Anonymous, 1918, p.185). As seen in the previous subsection, the popular use of shell-shock enabled certain empathy from the larger population to soldiers affected by war neuroses. The Lancet talked of "a formidable campaign of invective against the inhumanity of treating men with nervous symptoms as though they were either insane or malingerers" (Anonymous, 1916, p.627). In other words, the ways of treating soldiers affected by neuroses applied previously by the army, hospitalization in the asylum or punishment by death, were problematized as inhuman strategies to treat men who have experienced the difficulty of the war. To a certain extent, deviant conducts in the army become accepted, rejecting the clear division between "sane or insane" (Anonymous, 1916, p.627), opening the discourse to the concept of "borderline cases" (Anonymous, 1916, p.627). Neurosis was described as a condition "in which there is fair ground for hope of recovery under favourable conditions. It does not denote any permanent structural change

in the nervous system" (Anonymous, 1916, p.627) and, for this reason, it was considered as a treatable illness. This idea was new in the psychiatric discourse, because people affected by mental illness were exclusively treated under the Lunacy Act until 1930 (see chapter V), and insanity was considered a pre congenital condition having as the only solution the reclusion into the Asylums. The acceptance of the treatability of some cases allowed the rejection of a clear division between insanity and sanity and supported the existence of a linear continuum in the mental diseases. Patients were split between those still recoverable, and the "end-result" (Anonymous, 1931, p.81), and the focus of psychiatry was moved from the management of the psychiatric patients into the asylums, to the investigation of all the possible causes of this "tendency to emotional breakdown" (WOC, 1922, p.136):

> Every case of disordered conduct must undergo an exhaustive examination to determine the relative importance of the various aetiological factors, hereditary and exogenous, and how they can be modified. He strongly condemns the fatalistic attitude of those who explain every aberration on an hereditary basis (Anonymous, 1931, p.81).

The object of investigation of psychiatry was extended from the physical symptoms of mental disorders to any deviant conduct that was considered as a possible symptom of this emotional predisposition:

> This broad conception of psychiatry…concentrates attention, on the socially inefficient, the unemployable, the epileptic, the habitual offender, the prostitute, and all others who have not been able to tit themselves harmoniously into the fabric of society (Anonymous, 1931, p.81).

Psychiatry was defined as a "social and public health problem" (Anonymous, 1931, p.81) that should "be debated in the clear light of day, rather than behind the high walls of an institution" (Anonymous, 1931, p.81). As a consequence of this transformation in the psychiatric object of study, the efficacy of psychiatric hospitals was problematized as "the[ir] recovery-rate…show[ed] no appreciable tendency to rise" (Anonymous, 1931, p.81), and prevention and recovery were

suggested as more effective strategies for the treatment of mental diseases, compared to the admission into hospitals of severe cases:

> We must get in at the beginning…medically, socially, economically, it is better to centralise on the recoverable than to - care through a lifetime for those whose illness has been allowed to develop past all chance of betterment (Anonymous, 1931, p.81).

This new "broad conception of psychiatry" (Anonymous, 1931, p.81) was defined as *social psychiatry*. The next section will illustrate how WWII enabled the complete institutionalization of this new discipline. Specifically, it will discuss how the formation of new psychiatric practices, challenging the psychiatric hospital function, was central for the acceptance of the deinstitutionalization discourse.

Social psychiatry: a "contribution to the national life"

The previous subsections illustrated how the call for psychiatric and psychological knowledge outside the hospital's walls was not the direct result of medical progress, but rather it was chiefly related to a fault in the organization of the full army system. The war office committee (1922) was not limited to the definition of shell-shock, but it was also seeking a new "scientific method of guarding against its occurrence" (p.3). As seen, war neuroses challenged the army as a disciplinary system, and the punishment by death was problematized as an inefficient deterrent to malingering, and as an inhumane solution. In light of this, the report recommended the call for psychiatric expertise to reinforce the army system. Starting from these recommendations, this section will illustrate the formation of the psychiatric practices related to the social psychiatric discourse and implemented during WWII. Specifically, it will illustrate three of these new techniques, and how their contribution was not limited to the improvement of the efficiency of the army, but their application was acknowledged as beneficial for the larger society. These practices played a central role in the acceptance of deinstitutionalization in England, as they created the conditions for the externalization of psychiatric practices outside of the hospital setting, and the care of psychiatric patients in the community.

Before conscription, the Regular Army included trained men who voluntarily decided to start a military career. The soldiers who voluntarily, or under conscription, joined the army, by contrast, did not receive any training, and the latter group included also men who were enlisted against their will. The report noticed a relation between the approval of conscription and the increased number of neuroses in the Regular Army (WOC, 1922), reaching the conclusion that it "was certain that well trained and well disciplined troops were less liable to suffer from these troubles" (WOC, 1922, p.13). The WOC (1922) recognised also that "the incidence of "Shell-shock" varied inversely with the morale of the troops" (p.150). On the basis of these correlations, the WOC (1922) recommended the introduction of "adequate training" (p.150) for the "creation of morale" (p.150), and to prevent new neurotic epidemics in the army. A full section was dedicated by the report to this matter, and the following were some of the main indications:

> Training must be continuous. The more a man is trained the more skilful he becomes; the more skilful he becomes, the more his confidence increases. If a man knows he can do a thing well, he develops confidence in himself. If he knows that his comrades are equally skilful, he gains confidence in them. His confidence is multiplied. Confidence is both contagious and inspiring (WOC, 1922 p.208).

Training was described as something that can be accumulated and multiplied. The WOC (1922, p.208) stressed the role played by "mutual support" and "good team work" during the training because they can intensify the contagious characteristic of morale. Therefore, confidence was considered as something that can be reinforced in association with the "unity in the training" (WOC, 1922 p.208). On the other hand, the WOC also emphasised the importance of specific individual characteristics and attitudes as a requirement for effective training:

> The establishment and maintenance of discipline and morale as well as the cultivation of the fighting spirit and esprit de corps depend essentially upon an intelligent, accurate, and continuous appreciation of the mental calibre

and outlook of the soldier, and the continuous adaptation and modification of

his training to his psychology (WOC, 1922, p.166).

The WOC (1922) stressed "the importance of ascertaining, and giving due weight, to the mental and nervous condition of recruits" (p.169) during health examination, and to include "a note…on mental and nervous stability of each candidate on the Medical History Sheet" (p.171). Thus, selection and training were two of the main recommendations made by the committee in order to improve the troop morale and avoid new neuroses epidemics. Psychiatric and psychological were called to increase the efficiency of the army as a disciplinary system, through their expertise on the psychology of the individual.

WWII presented a new "opportunity" (Anonymous, 1914, p.1388) to implement these recommendations. As pointed out by Rees (1943): "modern war…demands a different quality of man" (p.2). Thus, psychiatrists and psychologists were called into the army to address "the ever-increasing number of questions which [were] brought up for psychiatric help or opinion" (Rees, 1943, p.2). Social psychiatry was entrusted with the implementation of new tools and methods for the prophylaxes of neuroses, in accordance with the War Office Committee's recommendations.

Following the report's recommendations, the first field in which psychiatrists worked was the "personnel-selection work" (Rees, 1943, p.6). Soldiers' psychological conditions were examined during the enlistment phase. According to Rees (1943), "Army psychiatry took the initiative in investigating and applying tests for personality and character studies. From this work has developed the specialized technique of the War Office Selection Boards for choosing officer candidates" (p.6). Soldiers were classified on the basis of their psychological traits. Psychiatrists created this tool to select the right subjects for specific positions working in "close co-operation with industrial psychologists" (Rees, 1943, p.6). While acknowledging *vocational test* as a "major contribution" (Rees, 1943, p.6) to the efficiency of the army with the reduction of "dulls, neurotics and unstable man" (Rees, 1943, p.2). Rees (1943) also stressed the importance of refining this "method for use in industrial selection in the future and for the sorting of any large groups of men or

women" (p.6). Vocational testing was validated as a new field for the application of social psychiatric knowledge aimed to improve the productivity of industry through the selection of the best man for the special place.

A further method developed during WWII was *group therapy*. The creation of this new psychiatric practice was justified in relation to the army hospitals' features, which were quite different from the ordinary psychiatric hospitals, as stated in the next quote:

> A mental hospital which is military as opposed to civilian can detain a patient without any need for certification, and a procedure has grown up in the Army by which officers or other ranks of either sex suffering from a recoverable psychosis can be kept in a military mental hospital before discharge for three or six or, in exceptional cases, nine months (Rees, 1943, p.2).

This absence of patients' certification (see the following chapter for an explanation on the legal procedures of admission and discharge in psychiatric hospitals) and shorter admissions were two important ruptures of the army hospitals compared to the civil one. As seen in the previous subsection, civilian psychiatric hospitals commonly dealt with the *end-result* and patients were supposed to be admitted for an unlimited stay without a real emphasis on their discharge. Thus, the main function of psychiatrists in the hospital was the management of the patients. Army hospitals, by contrast, were clearly aimed at the recovery and discharge of the soldiers, in order to enable them to go back to the front as soon as possible. This shift in the hospital's and psychiatrist's function required the application of a different therapeutic approach aimed at the rehabilitation of the patients. Group therapy was created in order to fulfil this new therapeutic goal and in relation also to the number and type of the patients of the Army hospitals. As stated by Bion et al. (1943),

> Under one roof were gathered 300-400 men who in their units already had the benefit of such therapeutic value as lies in military discipline…clearly this had not been enough to stop them from finding their way into a psychiatric hospital (p.678).

Psychiatrists were supposed to work as a disciplinary tool for those individuals who rejected the army control, and group therapy was the answer to all these specific needs. The main characteristic of this new method was the shift of the psychiatric attention from the individual to the group. As explained by Bion et al., "in the treatment of the individual, neurosis is displayed as a problem of the individual. In the treatment of a group it must be displayed as a problem of the group" (1943, p.678). As in the idea of epidemic, neurosis was described as "a danger to the group" (Bion et al., 1943, p.678), and the main of the psychiatrist was supposed to "ma[ke] [its display] the common aim of the group" (Bion et al., 1943, p.678). While previous therapeutic treatments focused on the individual following the medical model, in this case, the psychiatrist works in cooperation with the full group. According to Bion et al. (1943), *meetings* became a central therapeutic setting because they "[provided] an occasion for the men to step outside their framework and look upon its working with the detachment of spectators" (p.679). It was at this moment when the psychiatrist should help the patients to become aware of the disruptive effect of neurotic behaviour on the full group.

This social dimension was already present in the social psychiatry discourse after WWI, but it was possible to notice a further shift. During WWI, although the social context was acknowledged as a possible aetiological cause, the individual patient was still the passive object of the treatment. In group therapy, by contrast, the emphasis was given to "the study of the interplay of individual and social psychology (viewed as equally important interacting elements)" (Bion et al., 1943, p.681). The whole society and the individual were strictly interrelated so that they both became the objects of the psychiatric intervention. In this sense, it is possible to understand the relevance of this method for the larger society in peacetime according to the authors of the experiment. Bion et al. (1943) stressed that, in order to treat mental disorders derived by "psychological means", it is essential "to throw into prominence the way in which neurotic behaviour adds to the difficulties of the community, destroying happiness and efficiency" (p.678). In other words, the authors emphasised the importance to grow the awareness on the impact of

neurotic behaviours on the full society, as a preventive strategy for the onset of more severe mental diseases.

The acceptance of the treatability of mental illness, the acknowledgement of the vocational test as an efficient tool for selection, and the interaction of group dynamics in the adjustment of psychological issues enabled the complete acceptance of social psychiatry. The last method that will be discussed, namely the *therapeutic community*, integrated all these new elements of social psychiatry at once. This new method was implemented in a series of pilot experiments started during the war and completely established in the "Industrial Neurosis Unit at Belmont Hospital which was started in April 1947" (Jones, 1952, p.xiii).

As for the other psychiatric applications, the creation of this new method was justified by Jones (1952) in relation to "war-time needs with the huge volume of psychiatric cases and relative shortage of psychiatrists" (p.xiii), but also "to assist the Ministry of Labour in the resettlement of cases presenting special problems" (p.xvi). Despite their potential for future development in civilian life, previous methods were created to address specific army needs, the therapeutic community, by contrast, was already planned to satisfy both necessities. In 1944, the government ratified an act for the inclusion of disabled people at work (Disabled Persons (employment) act 1944), in order to address the increased manpower in the industry to provide for the man in age enlisted for the war. In accordance to this need, therapeutic community experiment was based on the belief that "the disabled man could be absorbed in industry with advantage to both [industry and disabled persons] in most cases" (Jones, 1952, p.xvi). As stated by Jones (1952), "[the aim of this method was to] find social and vocational roles for these patients in the local community while they were still in the hospital" (p. 16). The first experiment was aimed at the reintroduction of "the ex-prisoner-of war" (Jones, 1952, p.15), the later one, by contrast, was aimed to "the problem of the chronic unemployed neurotic" (Jones, 1952, p.25). It is important to stress again this shift in the function of the psychiatric hospital from being the place of the *end-result* to a

place with the aim to treat and "arrange resettlement" (Jones, 1952, p.25) of the patients.

Although these experiments were based on the idea of the treatability of mental disorders, it is important to notice that there was an exception. As stated by Jones, "we do not, however, accept cases which are frankly psychotic" (1952, p.25). As seen in the previous subsection, it was possible to notice a further fragmentation in the traditional division between sanity and insanity, people affected by mental disorders were further split among recoverable and irrecoverable cases on the basis of their "clinical characteristics" (Jones, 1952, p.25). This division was not limited to the "appropriate psychiatric treatment" (Jones, 1952, p.25), but there was a correlation between these clinical characteristics and also the possibility "to decide the most suitable job" (Jones, 1952, p.25). Thus, this method was based on the belief of the existence of a correlation between specific psychological, clinical and vocational characteristics, and the aim of psychiatrists and nurses in the hospitals was to "consider the patient to be fitted for such work before testing him out on the local community" (Jones, 1952, p.27). In this sense, the hospital worked as a sort of social experiment According to Jones (1952) "the patient was reacting to the hospital community in much the same way that he reacted to community outside" (p.27). The psychiatrist used the hospital and its social relations to readjust the patients and make them fit again for the life in the community. As for group therapy, *meetings* were favoured as a therapeutic setting to the one-to-one medical approach of the traditional psychiatry, which was previously applied in the hospital. This method enabled the transformation of the function of the psychiatric hospital, stressing the focus on the treatability of the patients, rather than on their exclusion and management.

This section has illustrated how the transformation of the English discourse and the formation of social psychiatry were strictly related to specific historical and national needs. However, the potential of social psychiatry was not limited to improvement of the efficiency of the army. It was also acknowledged as a "the contribution to the national life" (Rees, 1943, p.6). The call for psychiatric and psychological knowledge

outside of the psychiatric walls enabled the acceptance of objects which were previously excluded by the psychiatric attention, a shift in representation of the subject affected by mental illness, and the creation of new practices in other fields, such as industry. All these transformations allowed the problematization of the psychiatric hospital concerning its "suitability...for psychotherapy" (Bion et al., 1943, p.680), but also the potential of hospitals for the application of other methods, such as the therapeutic community. The next section will illustrate how different the historical conditions and needs that were related to the transformation of the Italian psychiatric discourse were.

THE NEW PSYCHIATRY IN ITALY

What is Psychiatry?[16]: the crisis of the institution

While the movement of the psychiatric care from the hospital to the community is usually explained as the result of a general development in the psychiatric understanding that involved the western countries, the previous section has illustrated how the formation of social psychiatry in England was strictly related to a specific historical context. The formation of the English social psychiatry discourse was characterised by very definite needs that impacted also on the selection of certain practices, such as the therapeutic community and the group therapy, rather than a strict Freudian psychoanalytical method, for instance. This section will show the historical needs and conditions that enabled the birth of what was defined as the "*new psychiatry*" in Italy[17] (Manacorda et al., 1977). As can be seen in Table 4, the formation of the Italian discourse was characterised by very dissimilar historical periods, and by a heterogeneous type of documents and practices, compared to the English one. This section will look at these differences in the historical conditions, objects, and practices between the Italian and the English psychiatric discourses related to the acceptance of deinstitutionalization policies in the two countries.

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[16] Original: "Cos'è la psichiatria?"- This was the title of the first book written in 1967 concerning the Gorizia hospital experience.

[17] Original: *La nuova psichiatria in Italia: esperienze e prospettive* (Manacorda et al., 1977). This was the title of a book aiming to outline the new psychiatric practices developed in Italy after the Gorizia experience.

RUPTURES in the new psychiatric discourse in Italy	**Problematization of medical psychiaty:** Reports from Gorizia Experiment	
	Officialization: TV and Radio documentary, photograph exhibition, conferences	
	New practices: Movement- Psichiatria democratica -Alliance with political parties, administrations, and working units	

Table 4- Ruptures in the Italian psychiatric discourse

The first divergence in the formation of the two national psychiatric discourses concerned the place where the transformation started. While the previous section traced the origin of social psychiatry in England in the military system during the wars, the Italian one developed "in the common scenario of a traditional psychiatric hospital - which was the one in Gorizia in 1961" (Slavich, 2014, p.183), after the arrival of a new director, who refused "to follow the simple mandate of conservation of the institution" (Slavich, 2014, p.187). The manicomio[18] was problematized as the place where "no one decides for himself" (Pirella, 2014, p.210). The psychiatrists involved in the Gorizia experience pointed out that their will was subjugated to the psychiatric institution, and Gorizia was an attempt to overthrow this pre-established structure (Slavich, 2014) in which their actions were dictated by the institution, rather than by an explicit aim. According to Basaglia[19],

> The psychiatric hospital seems to have its aims in itself, in the sense that the underlying work seems to serve only to keep it alive, without looking for anything that justified its function (2014a, p.19).

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[18] *Manicomio* was the traditional name of the Italian psychiatric hospitals. It can be translated as asylum. In this case, I am deliberately using it, as it was still commonly used by the Italian discourse with very negative connotations until the complete closure of them.

[19] Basaglia was the name of the new director of the Gorizia hospital, who started the Italian psychiatric reform.

Psychiatrists explained that there was no big difference between patients and psychiatrists because, as the patient had no possibility of choice once inside the manicomio, the psychiatrist, in turn, was built-in in this pre-established relation as well. According to this discourse, the psychiatric hospital was characterised by the complete absence of any "real role" (Basaglia, 2014a, p.19). In particular, the main criticism concerned the fact that, although the patient should be the primary goal of the full institution, this was not the case, as the patient was completely annihilated by the institution itself. As a consequence, "the only difference between the patients and staff [was] related to the authority and power given to them" (Basaglia, 2014a, p.20). The *new* Italian psychiatric discourse took its origins from this struggle (Foucault, 2009) of the psychiatrists against the type of authority given to them by the institution. Although the existence of the hospital and its staff (psychiatrists and nurses) were justified by the therapeutic goal, the psychiatrists questioned this and, as a consequence, also the authority ascribed to the medical staff. For this reason, the manicomio, with its hierarchy, alliances, division, and power, where the psychiatrists were an integral part, became the chief object of problematization of the Italian discourse.

Gorizia hospital was defined as an institution in a phase of *denial*[20] (Basaglia, 2014b). On the other hand, this process of demolition was not made in a casual manner, but it was the result of a systematic attack on the main features of the institution. The first step implemented by the professionals working in this experiment "was shortening the distance that separated the patient from the other figures [involved in the hospitals]" (Basaglia, 2014a, p.20). This action was aimed to overthrown the internal hierarchy of the manicomio, as the Italian discourse sustained that the elimination of the professionals' privileges, and the equalization of staff and patients, would have restored the therapeutic function of the hospital, and increased the role played by the patient in the relation with the doctor. All the actions that took place in Gorizia were aimed at a rejection of all the institutional

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[20] *L'Istituzione Negata* (the denial of the psychiatric hospital) was one of the most important statements that reported the process of transformation of the Gorizia psychiatric hospital.

norms, starting from the disruption of any forms of division. A journalist documenting his visit in the Gorizia hospital stated that:

> [An occasional visitor] of the Gorizia hospital will feel quite uncomfortable because he would be not able to understand the differences between patients, doctors, and nurses (Vascon, 2014, p.25).

The decision to open the units, to eliminate gender divisions between patients, and the use of special uniforms were all aimed at the removal of the forms of separation that characterised the psychiatric institution. This feature of the psychiatric hospital, of keeping the patients separated from the rest of the world, was further challenged through the abolishment of any boundary between the people in the hospital and the people outside. As narrated by the same journalist:

> The hospital was practically open to everyone: the standard sign, which severely forbids the access to the psychiatric hospital to those who are not authorised, was substituted with one that invites people to visit the patients at any time (Vascon, 2014, p.25).

This equality of the patients to any other member of staff and the endeavour to open up the space of communication between the patients in the hospital and the outside world were central elements of the style used by the documents concerning the Gorizia hospital. This period, in fact, was characterised by the production of various psychiatric texts that were the result of the collaboration between professionals and patients. Thus the transformation that was happening in the Gorizia hospital, this attempt to change the psychiatric institution, was not just a psychiatric experiment. It was described as:

> The action of overthrowing the institution, which doctors, psychologists, sociologists, nurses and patients have proposed and instigated in a psychiatric hospital, disputing the *manicomial* practices and conditions (Basaglia, 2014a, p.22).

The second important element of differentiation between the Italian and the English formation of the new psychiatric discourses was their underpinning

strategies (Foucault, 1972). Although both national discourses originated in a disciplinary space (Foucault, 2006), the birth of social psychiatry in England was the result of a series of counter-manoeuvres (Foucault, 2006) activated by the army and the ministry of pensions. In England, psychiatrists were called, at first, to solve a problem of efficiency in the military system and subjugate the struggle of the soldiers against the disciplinary military system, which was disclosed through war neuroses, and impacted also on pensions. Thus, English psychiatric knowledge was aimed at improving the efficacy of that specific disciplinary system. In Italy, the main aim of the discourse, by contrast, was to *overthrow* the psychiatric institution itself. The Italian psychiatric strategy was not to improve the efficiency of a disciplinary organization or prevent the spread of mental disorders, as in the English one, but it was the demolition of the full system within which the psychiatric institution and the psychiatrists were an integral part. This difference can be illustrated in relation to the diverse functions played by the application of the same methods: the therapeutic community. As seen in the previous section, the English therapeutic community experiments were aimed to build a method for the rehabilitation of the psychiatric patients into the hospital in the community, increasing the efficiency of the hospital. Gorizia was the first Italian hospital to apply the therapeutic community, explicitly inspired by Maxwell Jones (Basaglia, 2014a). On the other hand, "the *English model* was only felt like a starting point and not as a guide to follow step-by-step" (Pirella, 2014, p.219). The Italian discourse completely rejected the idea of creating a new model, or method, to use in the hospital, because the aim was its complete demolition. The therapeutic community method was defined as a "necessary step" (Basaglia, 2014a, p.26) for the rejection of the psychiatric hospital, but not "the ultimate goal" (Basaglia, 2014a, p.26). In other words, it was the first stage, breaking the traditional psychiatric institution organization, before completely demolishing it.

This rejection of new therapeutic techniques to apply in the hospital was also evident in the use of *meetings*. The previous section illustrated how group therapy and the therapeutic community applied meetings as a technique to treat the patient's symptoms using that space as an educative moment. The Italian

psychiatrists, by contrast, stressed that meetings, which were a central element in the life of the Gorizia hospital, were not used "as a *psychotherapeutic practice,* but as a way *of liberation"* (Basaglia et al., 1978, p.40) of the patients. Meetings were considered as having value only if they were the direct expression of the individual's decision, and this was considered a necessary condition for any activity of the hospitals. Nothing was considered compulsory. In this sense, it is important to stress that the main aim of the Italian psychiatric practices was "the conquest of the patient's freedom" (Basaglia, 2014a, p.25), and meetings made sense only in this perspective. The patient's *liberation* was a central object in the Italian psychiatric discourse. Yet but this was not meant as freedom from the illness or the symptom. The patient's liberation was related to the creation of reciprocal relationships between the professionals and patients in order "to give them the right to be citizens, to dissent and to protest" (Basaglia et al., 1978, p.74). Moreover, this *"freedom of choice"* (Basaglia in Vascon, 2014, p.30) of the patient did not concern only the individual. According to the Italian discourse, it was supposed to be included in a larger context, namely the whole community.

In order to understand the meaning of this link between the individual *freedom of choice* and the whole community, it is important to illustrate what the idea of treatment in the Italian *new* psychiatric discourse was. According to the Italian new psychiatry, mental illness could be treated as a "specific fact" (Basaglia, 1982b, p.9) through medicine, new therapeutic techniques and the opening of the hospitals, but all these actions were considered meaningless without fighting mental illness also as a "social fact" (Basaglia, 1982a, p.9). Basaglia (1982b, p.10) pointed out that:

> Once the patient has been discharged by the hospital…he will still face the same problem: the incapacity of our social system to accept those who have been rehabilitated…[because] the person does not have a place to go, or another social role to play [different from the sick one].

While in the English discourse, the aim of rehabilitation was the re-adjustment of the patient for the life in society through the elimination of their symptoms, in the Italian discourse, the focus was shifted from the illness to the relation between the

patient and society. Another central concept of the *new* Italian psychiatric discourse was that of *"putting in brackets"* (Basaglia in Vascon, 2014, p.32) the mental illness. In other words, patients were not treated on the basis of their diagnoses and symptoms, which was *put in brackets,* but people with mental illness were considered as "ill" because they were "excluded, abandoned by all" (Basaglia in Vascon, 2014, p.33), and their symptoms were considered as the signs of this exclusion. While in the English discourse, mental disorder was considered a danger for the whole society, in Italy, by contrast, people affected by mental illness were depicted as victims of society. Mental illness was not only an illness but a social problem among other social problems. As explained by Basaglia (1982a, p.442),

> Disadvantage had many faces: the one of starvation and destitution and the complete impoverishment of human existence or rules, prohibition, taboo, repression; class, race, colour, gender and role divisions. This is what constitutes the world of norms. From this indistinct ensemble of needs, there are some voices that try to scream their pain, furore and angriness, and it is in this moment that this will be labelled and muzzle under the name of 'illness'.

Thus, mental illness was equated to any other social problem, or form of division in society, it was the evident sign of a society that had, as the only solution for dealing with those individuals who did not fit into the norms, their isolation. It is important to stress that the existence of mental illness, as a proper illness, was never rejected by the Italian psychiatric discourse. Mental illness was a *specific fact,* but the problematization concerned the relation between the technical solution (e.g. diagnosis, treatments and psychiatric hospitals) and the social-economic system in which the patient was included. According to Basaglia (2014b, pp.30-31),

> Each society, whose structures are based only on economic-cultural discrimination and on a competitive system, creates some compensation areas that work as relief valves of the whole system. The psychiatric patient has played this function for a long time. If from one side, it is the social system that determines such conditions, on the other side, it is psychiatric knowledge that gives to this system a scientific validation.

The economic social context was the third element of difference in the conditions at the origin of the national psychiatric discourses. As seen in the previous section, the therapeutic community method and social psychiatry were developed in England as consequences of the increased request of manpower, both in the army and in industry. Basaglia (2014a) pointed out that, while in other countries it was possible to notice a transformation in psychiatric discourses, in Italy, by contrast, everything had remained unchanged since the first law on mental illness in 1904. The immobility of psychiatric practices in Italy was explained in relation to the problem of the larger Italian society, as the Italian system was not a "full employment economic regime" (Basaglia, 2014b, p.32), and, in particular, the 1960s were characterised by serious issues concerning the high level of unemployment. According to the Italian psychiatric discourse, the national political strategy was not interested in the rehabilitation of psychiatric patients, as society was not able to re-integrate them as productive members.

The Gorizia experiment was depicted as an attempt by the professionals to understand and offer new services based on the request made by the *"base"*[21] (Basaglia et al., 1978, p.34). Thus, psychiatric practices and hospitals were problematized not just in relation to their therapeutic function, but as part of a broader critique of society. According to Basaglia, the "transformation of a mainly agricultural culture to a different type of economy after WWII [in Italy], which saw the movement of people to larger cities" (Basaglia et al., 1978, p.33), enabled the "increased organization of the working class [and] the formation of different requests for social assistance" (Basaglia et al., 1978, p.34). The birth of the new psychiatric discourse was associated with this period of important social transformations that allowed the formation of a different request for social and health assistance. The Gorizia experiment was the attempt to "give an answer to a social class that did not want to be the subject anymore, neither of the psychiatric institutional violence nor of any other type of violence" (Basaglia et al., 1978, p.34).

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[21] This word was used by the Italian psychiatric discourse with an explicit reference to Marxist theory.

Thus the birth of the new psychiatric discourse was associated with the need for this new social class' consciousness.

While the English psychiatric discourse was the direct attempt of experts to sort out problems of efficiency in the system, and the strict reciprocal relation between experts and government strategies was evident, the formation of the Italian discourse was the result of a different economy of power. Psychiatric knowledge was problematized not because of its inefficacy, but because of its relation of power with a society based on the exclusion of non-productive, and the weakest, subjects. Thus the new Italian discourse was the attempt to overthrow this hierarchy of power and give voices to those who were excluded. In this sense, the psychiatric hospital was problematized as a place of exclusion. The next section will illustrate the second rupture of this discourse and how this led to the externalization of the psychiatric practices outside of the hospital setting.

Where does psychiatry go?[22]: the process of politicization

The last section partially introduced the rejection, by the Italian psychiatric discourse, of the oppressive function played by the psychiatric hospital. This section will analyse the relationship between violence and exclusion in the Italian discourse in more detail, looking at the process of *externalization* of psychiatric knowledge. It will also explain how the *social* element, which was a common object of the Italian and English social psychiatric discourses, had very different connotations.

As seen, the process of *externalization* of psychiatry in England took the form of a multiplication of the psychiatric sites and methods of treatment in the community. The birth of social psychiatry in England was associated with the proliferation of the fields of application of psychiatry like the army or industry. The aim of the psychiatric interventions moved from being strictly confined to the management of individuals affected by mental disorders in the psychiatric hospital to becoming focused on the prevention and rehabilitation of mental illness in the community.

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[22] Original: *Dove va la psichiatria? Pareri a confronto su salute mentale e manicomi in Italia dopo la nuova legge,* edited by Onnis L., & G., Lo Russo (1980). Although this text followed the approval of L.180/1978, I have decided to use the title from this texts as I believe it well-represents the second Italian rupture.

Thus, the problematization of the psychiatric hospitals in the English discourse was a consequence of this transformation of the psychiatric goal. In the Italian discourse, by contrast, psychiatric hospitals were the main object of problematization, and their critiques were more radical than in the English one. Psychiatric hospitals and psychiatry in general were not problematized because of their therapeutic efficacy/efficiency, but in terms of control and exclusion. Psychiatry was defined as "an invisible form of control" (Basaglia et al., 1978, p.59), and the manicomio was conceived as the maximum expression of this function. Thus, any form of psychiatric practice inside and outside of the hospital was rejected. This subsection will illustrate how these differences between the Italian and the English psychiatric discourses and practices led to the acceptance of very dissimilar forms of *externalization* of psychiatric knowledge outside of the hospital.

As seen, the first aim of the new Italian psychiatry was patients' liberation. Psychotherapeutic practices, including the therapeutic community, were supposed to allow "the take-over of the patients" (Basaglia et al., 1978, p.40) over the institutions and the present society that was excluding them. Psychiatric patients were associated with "poor people" (AA VV, 1972, p.8), but in the worst condition, as they were stripped of their only resources, namely "the productive capacity" (AA VV, 1972, p.8). A Marxist analysis was applied to the problematization of the relationship between patients and psychiatry: as unproductive members of society, "insane'" people were marginalised, and the real function of psychiatry was not their treatment, but their oppression (AA VV, 1972). It followed that any form of psychiatric practices, including the ones aimed at the rehabilitation of patients into the community, were rejected as new forms of the patient's repression.

> The new social psychiatrist, the psychotherapist, the social worker, the psychologist and the sociologist working in the industry sector were only some of the examples of the new administrators of power, who, with their techniques apparently curative and non-violent, allowed the perpetuation of the global violence. Their function, defined as *vocational- therapeutic*, was

aimed at adapting individuals in order to accept their condition of 'object of violence' (Basaglia, 2014d, p.116).

Violence was not just limited to the exercise of physical force, but included also, and in particular, any form of oppression and exclusion. In this sense, it is important to stress that a wide range of psychiatric practices was rejected from the use of ECT and psychiatric drugs to psychiatric diagnoses. Psychiatry was further problematized in the attempt to verify if it was possible to shift it from being an institutional practice to becoming a political one, as "a form of class struggle" (Jervis, 1977, p.29). If from one side, the Italian discourse was seeking to avoid the recreation of any new psychiatric practices aiming to readjust the individual outside of the hospital, on the other, it was looking for a way to elude the risk to circumscribe the critiques against psychiatry at the psychiatric hospital. In other words, the Italian discourse against psychiatry and institutions was looking for a way to become external to the setting of the psychiatric hospital, but without taking the shape of a new psychiatric practice. Instead, it was meant to take the shape of a political "revolution" (Jervis, 1977, p.130).

In the middle of the 1960s, Gorizia was no longer an isolated case. Its example was followed by other psychiatric hospitals all around Italy. In this common attempt to close down the hospitals, the main problem the Italian psychiatrists were facing was related to the satisfaction of all the daily needs of the psychiatric patients in the community. The strategy used by psychiatrists for addressing this urgent need of the patient was still to *put into brackets* mental illness as an illness and to consider only the social element of it. The focus of the psychiatric discourse was further moved from the individual and the illness to the whole society. As explained by Basaglia et al. (1978, p.52),

> When an ex-resident of the hospital, or a psychiatric patient, does not have clothes, does not have a house, does not have a wage, a common problem was raised, namely the issue of clothing, of housing, of employing that no one has. At this point, the stone that has been thrown to report a deficiency in the psychiatric institution unravels all the injustices in society.

In other words, the deprived conditions of the psychiatric patients in and outside the hospital were considered by the new psychiatric discourse as a mirror of the problems of the wider society. Patients affected by mental illness became the emblem of the misery of contemporary Italian society, and the process of discharge, from being an event involving the patient as an individual, became an event involving the entire community. Although this might be reminiscent of the English social psychiatry discourse, which considered mental disorder as having a bad impact on the happiness of the whole community, in the Italian discourse community was involved in the process of discharge of the patient, not because the latter was considered a danger for the community, but because a deficiency in the satisfaction of the patient's need was the sign of a possible deprivation of any member of the community. While in the English discourse the psychiatrist's function was to check if the patient was fit to be reintroduced in the society, the function of the Italian psychiatrist, by contrast, was to create awareness of the condition of the psychiatric patients to improve the life in the community for all.

As seen, this identification of the population with the patients was a central element of the new Italian psychiatric discourse. But the focus of the discourse was not limited to the psychiatric context; it moved "to another new level" (Basaglia at al., 1978, p.53). From the psychiatric institutions, the Italian discourse took the shape of a "political project" (Jervis, 1977, p.40) involving the wider society, and the "histories of all the patients were used as only one manifestation of a broader public protest" (Basaglia et al., 1978, p.34). The psychiatric institution, from being one of the places of normalization *par excellence* (Foucault, 2006), was turned into the place that can bring awareness about the conditions of all marginalised people, and the Gorizia experiment was transformed into an experiment of democratic political management based on "self-government" (Slavich, 2014, p.179). This form of government was based on the overthrow of all the given divisions and authorities through "the appropriation of knowledge from all the patients (knowledge is power)" (Basaglia et al., 1978, p.67), and the overthrow of any division between technicians and patients (Basaglia et al., 1978). As Basaglia explained:

The opening of a psychiatric hospital is an act of protest. If one patient says: 'I will crush a window!' and the psychiatrist says: 'Well, let's crush it together!' Your words start an exchange of ideas that is not on the technical level anymore, but rather on a political one. In this moment, an individual condition becomes a collective one (Basaglia et al., 1978, p.75).

The *externalization* of psychiatry, which in England took the shape of new methods and techniques, in Italy was characterised by the attempt to extend the discourse against the institutions, which started in the psychiatric setting, to the whole social system. The condition of the psychiatric hospital was associated with the one of the "family, school, factory, university, hospital" (Basaglia, 2014d, p.115), as all these institutions shared a clear division of roles and a certain "division of power" (Basaglia, 2014d, p.115). The discourse was characterised by a continual link between the psychiatric institution and the problems in the rest of the society, like in the following example, which linked the Italian strikes from 1968 to the end of the 1970s to the psychiatric reform:

It was possible to see how the general protest of the population asking for work, better wages and fair living conditions, coincides with a similar protest in the psychiatric hospital (Basaglia et al., 1978, pp.37-38).

The psychiatric struggle, and this political strategy, took shape in a movement, namely *psichiatria democratica* [democratic psychiatry]. According to the manifesto,

[The chief aim of the organization was] to continue the struggle against the exclusion, analysing and denouncing all their sources in their structural aspects (i.e. social relationships based on production) and suprastructural one (i.e. norms and values of our society) (Anonymous, 1979, pp.178-179).

Clearly, the Italian Psychiatric discourse was not aiming to transform psychiatric knowledge and practices, but to transform society. The Italian process of *externalization,* rather than looking for methods to apply outside the hospital, was based on the construction of external alliances with other movements that shared

this struggle, as explained in the following passage from the manifesto: "this struggle can carry on only by linking all the forces and movements that, sharing the same analysis, act concretely for the transformation of this social aspect" (Anonymous., 1979, p.179). These alliances with other groups with similar aims enabled the multiplication of the sites of discussions of the psychiatric objects.

As seen in the previous subsection, during the 1960s Italy was in a period of important social and political changes, characterised by the reorganization of the working trade unions. Psychiatry became an object of discussion often related to the workers' struggle. In a conference with the eloquent title of *Psychology, psychiatry and power relationships*, Berlinguer[23] (1979) included psychiatry among the political issues that required urgent attention. The conference was described as,

> A cultural meeting and a moment of struggle… against this oppressive society, the segregating institutions, and psychiatry and psychology, which were at the service of the exploitation of man by man, [and]…a moment of internal development of the workers' movement in the cultural environment of the Italian left political parties (Berlinguer, 1979, p.112).

The psychiatric discourse engaged in forms of communication that were different from the traditional channels used by the experts, such as academic papers. In this period the multiplication of statements disseminated through mass media such as TV documentary exhibitions of photographs and radio programs was noticeable (Zavoli, 1968; Peltonen, 1968; Agosti, 1975). The target of these was not the dominant class, but the full population, as explained in this quote: "[the psychiatric experiment in Turin] was aimed to raise public awareness with debates, meetings on social-political issues related to the psychiatric problem" (AA VV, 1972, p.8).

While in England, the discourse on deinstitutionalization reinforced the relation between knowledge and government, like in the report on shell-shock, the Italian discourse, by contrast, saw the formation of a new relation between experts and

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[23] Berlinguer was the brother of one of the most popular Italian politician of the Italian Communist Party (PCI): Enrico Berlinguer.

those groups that usually were the object, rather than the subject, of power dynamics. This process of the extension and involvement of the *base* in the production of knowledge was labelled a "socialization of knowledge" (Basaglia et al., 1978, p.33). The Italian psychiatrists, as intellectuals, defined themselves as "code breaker" (orig. decifratore di senso, Basaglia et al., 1978, p.26), in other words, those who can give a meaning to things, but they refused to use the power associated with their knowledge to continue the process of normalization of the social order. They decided instead "to use their power in an alternative way" (Basaglia et al., 1978, p.26): promoting awareness among the minority groups and overthrowing the power kept by the dominant class (Basaglia et al., 1978). According to this discourse, "the appropriation of knowledge…enables the transformation, at first, of their own status, and after, the transformation…of the general status quo" (Basaglia et al., 1978, p.67). Italian psychiatrists, together with other professional groups (e.g. magistratura democratica, medicina democratica), decided to become a tool in the hands of subaltern classes, rather than of dominant groups and institutions, as explained in this quote: "only the proletariat can change society and the intellectuals can only mirror the transformation" (Basaglia et al., 1978, p.131). In this sense, it is possible to understand how the process of liberation of patients was associated, and extended, to the process of liberation of society as a whole.

To sum up, I will conclude this subsection with a direct quote from one of the Italian psychiatrists, comparing the Italian psychiatric reform to the transformation of psychiatry in other countries:

There was an essential difference between the psychiatric reform in Italy and abroad. While in France the psychiatric movement was based on technical issues, it was focused on therapeutic problems, in Italy, by contrast, it was mainly a movement of transformation in the way of staying together, in the way of communicating and organising against the oppressor, perfectly in line with the quality of the struggles of the workers' trade union (Basaglia et al., 1978, p.42).

Although the comparison was made with the French experience, this subsection showed how this was the main element of difference also with the English psychiatric discourse. The next section will stress this dissimilarity between the Italian and English discourse even more by looking at the anti-psychiatry movement.

Anti-psychiatry and the new psychiatry in Italy

The previous subsections showed the differences in the conditions that enabled the problematization of the psychiatric hospitals in Italy and in England, and how these impacted on the formation of the two national psychiatric discourses and practices. Despite these differences, the English and Italian discourse shared some elements, such as criticisms of the hospitalization of patients, the application of the therapeutic community, or the centrality given to the social dimension. As seen in chapter II, previous studies on deinstitutionalization focused on these commonalities, rather than stressing their differences. An example of this tendency to assimilate heterogeneous elements from different national discourses under univocal comprehensive categories was the use of anti-psychiatry as a label referring to any critique of psychiatry and hospitals (Jones, 1993; Miller, 1986). Although there were reciprocal attention and interest between the Italian psychiatrists working at Gorizia and the English anti-psychiatric experiences conducted by Cooper and Laing, their works were very different. This section will focus on the main objects that characterised these two national critical approaches to psychiatry, in order to further stress the differences in the psychiatric discourses in the two countries. Before starting the comparative analysis, there are two characteristics of this subsection that need to be noted. First of all, the analysis refers only to two English documents, thus it does not aim to offer a complete analysis of the whole anti-psychiatric movement. Secondly, this section diverges from the previous ones, as it will consider an experience that succeeded in the English historical period analysed by this chapter. Villa 21 was almost contemporary with the Gorizia experience, and they shared the strong rejection of traditional medical psychiatry and the psychiatric hospitals. This element notwithstanding, this subsection is still consistent with the main aim of this chapter, namely to stress how

different economies of power enabled the formation of different discourses. This comparison can illuminate how similar practices, like these two anti-institutional experiences, can still be the product of different problematizations and power strategies.

As seen, the new Italian psychiatry looked at the English experiences. Gorizia was inspired by Maxwell Jones, but this was not the only link with the British world. Laing's and Cooper's experiences were also sources of analysis and reflection, aiming "to comprehend how, and if, their practices can help to better understand [their] own experience" (Basaglia and Basaglia-Ongaro, 2009[1975], p.71). Maxwell Jones, Laing and Cooper were used by the Italian psychiatrists as a mirror of their own experience, but they were also the sources of strong criticisms.

The Gorizia hospital was the first Italian experience to experiment with the therapeutic community in 1961 with the aim to overthrow all the main characteristics of a traditional Italian psychiatric institution. Villa 21 was "an experiment in anti-psychiatry" (Cooper, 1974, p.96) started in London in 1966. As in Gorizia, Cooper (1974) explained in his report that:

> We have progressively and successfully eliminated many destructive aspects of psychiatric institutional life. We have eliminated formal hierarchization…rid ourselves of the rigid grading of inmates into patients and staff…we have refused to isolate the hospitalized member of a family 'the ill one' (pp.112-113).

While this description might seem quite similar to the Italian experience illustrated in the previous subsections, there are important elements of distinction between the two discourses: firstly, the explanations of these transformations. As seen, the beginning of the Italian transformation was explained as "the demolition of the chain of the institutional power proxies" (Slavich, 2014, p.187). In other words, the director and one doctor rejected their own authorities and the pre-established structure of the hospital, starting the overthrow of the institution. Cooper's transformation of the unit's organization, by contrast, was depicted as a strategy to push away the patients from "the matrix of family-worlds, where its real problems

arise and where their answer lies" (Cooper, 1974, p.116). While in the Italian case, the restructuration of the hospital was associated with the refusal of a specific type of power by those who owned it (the director and the doctor), in the English one, the transformation was related to a specific theory about the causes of the mental illness problem. According to Cooper's approach, in fact, the main cause of the onset of schizophrenia rested in the family, and "in the mental hospital, society has, with unerring skill, produced a social structure that in many respects reduplicates the maddening peculiarities of the patient's family" (Cooper, 1974, p.35). Psychiatric hospitals were not problematized because of their internal power dynamics, but because they reproduced a context that according to the author was *maddening*.

It follows that a second important difference concerning the two approaches was related to the representation of mental illness. According to Cooper (1974), "mental health" coincides with a "boxed life…from birth to death" (p.32): each individual from birth to death is taught to be, and behave, in a certain way according to certain norms. Cooper (1974) stated that "the job of a mother is to produce not only a child, but a field of possibility in which her child may become someone else, another person" (p.36). When this does not happen, when "the process of becoming a person…go[es] wrong" (Cooper, 1974, p.36), the person may experience a mental disorder, as the person "lack[s] … the precondition for the realization of his personal autonomy" (Cooper, 1974, p.36). Mental disorder was acknowledged as a personal issue that is developed during the process of education in the family, and it was strictly related to the individual capacity to achieve his personal *autonomy*. This representation of mental illness differed from the one of the Italian discourse, which shared this social dimension of mental illness, but not in terms of education or impact of the social relationships on the individual, but in relation to social economic structures of society (Basaglia, 2014a). As seen in the previous subsection, the Italian psychiatric discourse did not consider mental disorder as a problem in the development of the individual *autonomy,* but as a problem of *freedom* due to the lack of opportunity in the social system. In this sense, it is important to stress that the two discourses were focused on two

different objects: while the English one was still looking at the individual, despite the fact it was in his family context, the Italian discourse moved the object of the psychiatric attention from the individual, the illness, and the social relationships, to the whole society.

This was even more evident in the different strategies applied to solve a shared theme: the one of *violence*. In both discourses, there was a link between psychiatry and violence:

> At the heart of our problem is violence. The sort of violence that I shall consider here…has little to do with people hitting each other…and about what crazy mental patients are supposed to do (Cooper, 1974, p.29).

But Cooper (1974) specified that he is talking of the "violence that other people, the 'sane' ones, perpetrate against the labelled madmen" (p.29). As seen in the previous subsection, Italian psychiatrists used the word violence with a similar connotation, and they also acknowledged the patient as a victim of psychiatry. On the other hand, while the Italian discourse reacted to this violence through the refusal of re-creating any other psychiatric method, as stated by Basaglia (2014d, p.117), "we can only reject any therapeutic attempt aimed only to mitigate the reactions of the excluded against the excluder", Cooper, by contrast, with Villa 21, attempted the creation of a new technique based on *anti-psychiatry*. In the last chapters of his report, in fact, Cooper (1974) "outlined the principles and practice of an experimental therapeutic unit for young schizophrenic patients" (p.12). Although he problematized the "institutional irrationality" (Cooper, 1974, p.12), he explained that his treatment was based on a "family-oriented therapeutic ideology" (Cooper, 1974, p.12). In other words, while the English anti-psychiatric discourse can be described as an epistemological opposition to the medical approach to mental illness, the Italian new psychiatric discourse was generated by a struggle against the established relationship of power between psychiatrist and patient.

The Italian psychiatric discourse problematized Cooper's antipsychiatry as a further "ideological mystification" (Jervis, 1977, p.126). English anti-psychiatry was

criticised because if, from one side, it enabled the demolition of some taken-for-granted ideas on psychiatry, on the other side, it allowed the formation of a new technical discourse, which was different from the medical approach to mental illness, but still in the hand of few experts. The Italian discourse acknowledged that:

All the theoretical and practical ruptures in psychiatry were all symptoms of, and a boost for, social transformation: the evident sign of cultural innovative movements…in the bourgeois awareness. [However], it was not difficult to show that all these changes have been only progresses, but never a real revolution, and they led to an even stronger reinforcement of the social control (Jervis, 1977, p.130).

Two elements are essential in these passages. First of all, the meaning of revolution had, as seen in the previous subsection on the Italian discourse, a very strong political connotation. The Italian psychiatric discourse was aiming to transform the entire society, rather than to improve the management of mental illness. Secondly, antipsychiatry was criticised as only another transformation in the history of psychiatry, and it was even associated with the birth of psychiatry during the Enlightenment, when Pinel introduced the open door and reduced physical constraints. In this sense, it is interesting to point out that the Italian psychiatrists, by contrast, defined themselves as the "last sons of Pinel" (Basaglia et al., 1978, p.24), in other words, they aspired to be those who put an end to the psychiatric discipline.

While the Italian psychiatric discourse and the Gorizia experience were born of a rejection of a certain economy of power that used psychiatry as a scientific legitimization, Cooper's theory and Villa 21 were not rejecting their psychiatric function, but only the medical approach, in line with the discourse outlined in the English section. Laing was critical of both the psychological and medical approach to mental illness, and, in particular, he problematized human behaviour as an object of study of psychiatry:

We can see other people's behaviour, but not their experience. This has led some people to insist that psychology has nothing to do with the other

person's experience, but only with his behaviour…the task of social phenomenology is to relate my experience of the other's behaviour to the other's experience of my behaviour. Its study is the relation between experience and experience: its true field is inter-experience (Laing, 1967, p.15).

Like Cooper, Laing ascribed a central role to social relationships and to how individuals influence one another. Laing's and Cooper's thoughts were based on a specific paradigm: the phenomenological one, based on the experience of the individual. Although they acknowledged the role of society during the labelling process of psychiatric patients, their focus of study, and intervention, rested on the individual and his or her personal experience. The Italian discourse, by contrast, problematized the psychological approach to mental illness not as a method, but because it "mixed the personal condition…with the political problem" (Basaglia et al., 1978, p.66). In other words, psychological explanations were rejected because they explained any problem using individual motivations, obscuring the political issue related to it.

This difference in the object of the transformation, the individual in Laing and the whole society in the Italian discourse, was also reflected in the relationship with the institutions. The Italian and the English critiques to psychiatry were characterised by two different strategies, as explained in a debate between Basaglia and Laing focused on "the controversy problem of acting inside or outside of the institutions" (Basaglia and Basaglia Ongaro, 2009[1975], p.71). During this exchange between the Italian and English experiences, Laing stressed the power of the institutional control outside of the psychiatric hospitals:

LAING: We always talk about the limits of working in the institutions…High public positions are controlled by politics…everything is controlled by forces that are not medical…these limits are always present and stop any attempt of radical actions (Laing in Basaglia and Basaglia-Ongaro, 2009[1975], p.71).

Laing was referring to his experience in the psychiatric hospital during the 1960s emphasising that any attempt to do something different was interrupted. The

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author explains that the problem is not just medical, but it concerns also the bureaucratic and legal organization around the institutions that prevent to work in a different way. For this reason, he explained that his final decision was to "leave the system" (Laing in Basaglia and Basaglia-Ongaro, 2009[1975], p.71). His final solution was to work in the psychiatric institution but offering an "alternative" (Laing in Basaglia and Basaglia-Ongaro, 2009[1975], p.71) to the normal way to be in the institutions. Basaglia, by contrast, rejects this idea of "resting in the middle" (Laing in Basaglia and Basaglia-Ongaro, 2009[1975], pp.72-73), sustaining that the alternative must exist outside of the psychiatric hospitals, available to all. As explained by Basaglia, "actually, *being outside of the system* does not exist, the relations between outside and inside are continual. It is just a matter of how one looks at things" (Basaglia and Basaglia-Ongaro, 2009[1975], p.72). A central element of the Italian psychiatric discourse was that the discourse could not be limited to the psychiatric setting, but it concerned the whole society. In other words, the rejection of the institution was not only of the psychiatric one but of any institution and its political organization. While Laing sustained that it was impossible to transform the politic organization, Basaglia argued that this was possible and this was supposed to be the main objective of the psychiatric discourse.

This attention on the political dimension was the main difference between the Italian and English critiques of psychiatry, and, in this sense, anti-psychiatry was defined by the Italian discourse as a "misunderstanding" (Jervis, 1977, p.136), as "in the actual fact, anti-psychiatry was still psychiatry" (Jervis, 1977, p.136).

Conclusion

This chapter has illustrated the relationship between the specific social, historical and political conditions and the formation of the national psychiatric discourses, which led to the acceptance of the deinstitutionalization discourse. Psychiatric knowledge and its practices were shaped by specific national, historical needs and the economy of power in which they were included.

In this sense, the chapter has confirmed the productiveness of an analytical approach to deinstitutionalization based on contingencies, rather than commonalities and comprehensive explicative models, such as those applied by previous historical accounts on the matter. This attention of the differences allowed me to retrace the origin of the English and Italian psychiatric discourses in very different contexts, the army and the manicomio, and in two very diverse historical periods characterised by specific needs. While the English psychiatric discourse originated in order to address the needs occurred in the army during WWI and the increased manpower needs, in Italy, the new requests made to psychiatry were raised in relation to the need of a new working class.

The archaeology of knowledge enabled a challenge to the idea of a monolithic knowledge produced by something external, such as progress (Jones, 1972), or in the hands of dominant classes (Scull, 1986), and a study of it as a social phenomenon, and, as such, embedded in multiple relations of power. The chapter, in fact, illustrated how national experts played very different roles and were included in various types of alliances. While the English discourse was the result of a reciprocal relation between experts and government, as stressed by the use of specialist language and references from research to justify political strategies, in Italy, by contrast, the new psychiatric discourse was the result of the rejection of this alliance between political class and intellectuals, who decided to give voices to the base.

The chapter also showed how different discourses can take different forms, such as create new techniques or organization, but also how similar methods can be the consequences of very different discourses and strategies. While in England, the army needs originated new methods, such the group therapy, that is still a central psychotherapeutic practice; the Italian specific needs enabled the formation of a political discourse that was central for the formation of the present Italian welfare state.

In this sense, this chapter partially confirmed the analysis made by governmentality studies of the link between the extension of psychiatric

knowledge in other fields different from the psychiatric hospitals and the governmental formation (Rose and Miller, 1988; Miller and Rose, 1986; Rose, 1985; Castel et al., 1982). But it also diverged from them. Data, in fact, illustrated the impossibility to generalise the results of the analysis of one national experience, such as England, to all western countries. This was particularly evident in the section comparing anti-psychiatry and PD: although both movements were based on a common critical approach to psychiatry, their struggles were based on very different strategies.

This strict correlation between knowledge, institutions, and groups of power will be illustrated in even more detail in the next chapter. This will look at the acceptance and transformation of the legal discourses concerning the management of mental illness in relation to these new psychiatric discourses.

CHAPTER V: THE FORMATION OF THE DEINSTITUTIONALIZATION DISCOURSES IN ENGLAND AND IN ITALY

Introduction

The shift of psychiatric care from the institutions to the community was not just related to the transformation of psychiatric knowledge, but also to substantial changes in the policies and legislations controlling the management of mental illness. The ensemble of these specific policies, which regulated this movement, is commonly defined as deinstitutionalization (Etzioni, 1975; Bacharach, 1976). This change involved transformations in the governments' rationales, procedures and institutions that were not limited to a transformation in the psychiatric provisions and the management of mental illness, but included a complete reformulation of the legal machinery concerning the treatment and care of mental disorders (Jones, 1972; Laing, 1999; Rose, 1985; Gostin, 1983). The laws marking the beginning of this process in England and Italy were respectively the Mental Health Act 1959 and L. 180/78. The aim of this chapter is not to write a new history of deinstitutionalization in Italy and in England starting from the approval of these laws (Bennet and Morris, 1982; Burti, 1994), but to inspect the conditions that enabled the acceptance of these changes in the two countries.

In order to achieve this aim, the chapter will consider the complex relations between authorities, belief, forms of knowledge and techniques (Dean, 2010) that underpinned the formations of the national discourses on deinstitutionalization. The notion of governmentality (Foucault, 2009; Dean, 2010; Miller and Rose, 2010) will be applied as an analytical device. According to Lemke (2007), the studies on governmentality are characterised by the analysis of three main elements: the relationship between knowledge and political discourses, techniques (e.g. procedures, apparatuses or documents), and the construction of political strategies in relation to specific problematizations. Thus, the conditions of the formation of the national deinstitutionalization discourses will be considered in relation to the transformations of the national policies and psychiatric knowledge outlined in the

previous chapter, the shift in the legal documents and procedures concerning the management of mental disorders, and in the rationales at the basis of government re-organization.

The first section of this chapter will outline the emergence of the conditions that allowed the acceptance of the deinstitutionalization discourse and the movement of psychiatric care from the institution to the community in England. The second section will investigate the Italian conditions that enabled the acceptance of the laws related to the treatment of mental illness in the community. Specifically, the second section will stress the differences between the Italian and the English political strategies that led to the validation of the national deinstitutionalization discourses.

THE FORMATION OF THE ENGLISH DEINSTITUTIONALIZATION DISCOURSE

The Lunacy system and double standards

The aim of this section is to illustrate the main ruptures (Table 5) in the English discourse that allowed the acceptance of the legal discourse on deinstitutionalization with the approval of the Mental Health in 1959. Before investigating the emergence of these conditions, it is essential to outline the English management of insanity before the twentieth century.

Until 1913, the main regulation concerning insanity was the Lunacy Act 1890. This was the last of a series of laws started in

Table 5- Ruptures in the English legal discourse

First Rupture	1913- Mental Deficiency Act
	1919 - Ministry of Health Act
	1924 - The Royal Commission on Lunacy and Mental Disorder
	1930- The Mental Treatment Act
Second Rupture	1946- National Health Service Act
	1951- Report of the Committee on Social Workers
	1956- The Royal Commission on Lunacy And Mental Treatment (Percy Report)
	1959- The Mental Health Act

the eighteenth century, and its aim was "to consolidate" (Lunacy Act, 1890) the system previously framed by them. Although the Lancet (1897) stated that one of the main areas of improvement, according to the memorandum of the law, was "to remove the difficulty then felt in securing the speedy treatment of mental disease" (Anonymous, 1897, p.52), it is important to stress that this Lunacy Act was concerned with the treatment of lunacy not as a health issue, but as a problem of public order. This law, in fact, dealt only with those individuals who "[denoted] a derangement of mind and a purpose of committing suicide or some crime" (Lunacy Act, 1890, sec.4). The medical treatment of mental illness, by contrast, had no regulation, and the law did not interfere with the private care of mental illness until the "malady…[had] become apparent…to require…coercion" (Lunacy Act, 1890, sec. 64).

The Lunacy Act 1980 differed from previous Lunacy Acts as it introduced a compulsory procedure for the admission of patients into the asylum. As clearly stated, "no person not found lunatic by inquisition shall be received into any asylum hospital or house licensed under this Act" (Lunacy Act, 1890, sec. 13). The English system of this period did not concern all individuals of unsound mind, as mental illness was not enough for the subject to be dealt with by the lunacy act. The law dealt only with those lunatics who required coercion, but even committing a crime was not a sufficient condition to be processed under the lunacy act. In order to become a patient under the Lunacy Acts, it was necessary that the subject was certified as insane: a specific status acknowledging him as both of unsound mind, and having the intention to commit a crime. This certification worked as a proper "dividing practice" (Foucault, 1982, p.777), giving to the subject a permanent legal status, which was not just the representation of their medical condition. In other words, certification classified patients not because they were affected by mental illness, but because of their continual and potential dangerousness. This representation resembled the figure of the immoral monster introduced by Foucault in the lectures on the abnormals (Foucault, 2003): the dangerousness ascribed to the lunatics after their certification was different from the one of the common criminal offenders because their immoral act originated in their mental

condition, rather than a rational motivation. Lunatics' immoral acts were neither preventable nor corrigible, but they were embodied in the lunatic himself. For this reason, the only solution was the complete isolation of these cases from the community. In accordance with this clear separation between sane and insane, once an individual was certified as insane, he was stripped of their possessions and segregated in an institution, applying a strategy very similar to the isolation of lepers (Foucault, 2003).

As explained by the manual on the Lunacy Law, the chief problematization behind this procedure was related to the safeguarding of the insane with means (Fry, 1890). The management of lunatics with means was considered, in fact, an issue in relation to the abuses of power from their guardians since "the early state of the law" (Fry, 1890, p.5). The civil law provided that any person who was considered not able to manage their property was supposed to be under custody. This category included not just the idiot and the lunatic, but also "unthrifts, or prodigals" (Fry, 1890, p.3), as the law had as its main aim the protection of estates. Although the English law agreed with the civil law on the necessity of the legal guardianship of the individuals of unsound mind, this was limited to the lunatic and the idiot, as the principle of "*sic utere tuo, ut alienum non laedas* [was] the only restriction [the common] laws have given with regard to economic prudence" (Fry, 1890, p.5). In other words, the way of managing property was considered an element of individual liberty and, as such, it was not supposed to be invaded by the law but rather protected. As a consequence, the legal supervision of property was required only if there were evident signs of "unsoundness of mind" (Fry, 1890, p.5). Thus this procedure of certification did not concern only the dangerousness of the patients, but it was a further element of safeguarding to avoid unfair segregation of lunatics with means. The Lunacy Act 1890, in fact, provided also further forms of safeguards such as a special commission to verify the mental condition of the individual (Lunacy Act 1890, part IV), procedures for the registration and licensing of the places for the reception of lunatics (Lunacy act 1890, Part II, Div. 2-3), and their regular visitations. Moreover, the medical men who signed certifications were

obliged to demonstrate the proof of their decision in front of a judge of the court (Fry, 1890, p.35).

However, certification was not applied only to patients with means. This procedure was compulsory for all patients, but the process differed on the basis of their class. Procedures for private patients were more complex than those for pauper lunatics: while the former required two medical certificates different from the medical practitioners and that of the commission in lunacy, the latter was straightforward, with only one medic and one judge. The act, in fact, acknowledged "three classes of Lunatics…namely, Private Lunatics, Pauper Lunatics, and Criminal Lunatics" (Fry, 1890, p.1). The first two groups were distinguished on the basis of their ability, or not, to pay for their treatment; the third group included those individuals who had committed a crime and turned lunatic while they were serving a sentence in prison. For the purpose of this research, only the first two groups will be analysed.

It follows that, after a first division between sane and insane on the basis of the dangerousness of the individual affected by mental illness, the insane were also subject to a further segmentation on the basis of their means. This internal division of the insane resembled the plague model used by Foucault (1995) to describe the disciplinary *dispositif*. This segmentation, in fact, allowed the distribution of the subject in fixed places and their continual surveillance through a system of permanent registration.

This division and the introduction of certification allowed also the reinforcement of the central control over the local authorities. Before the Lunacy Act 1890, not all boroughs provided for special institutions for lunatics but pauper lunatics were kept in asylums, workhouses, or poorhouses, which were regulated by different laws and authorities, as explained by Fry (1890),

> The relief and treatment of pauper lunatics [was]…a mixed subject…under the control of two distinct central authorities…[namely] the Commissioners in Lunacy…[and] the Local Government Board (p.47).

While the former was under the control of the Secretary of State, the latter were part of the local authorities. The approval of the Lunacy Act 1890 reduced the number of institutions and authorities involved in the management of insanity with the establishment of one public asylum for lunatics of any county as a positive duty. Moreover, it provided that

> Every asylum and hospital and every licensed house for the reception of a single lunatic shall without any previous notice as often as the inspector or an official visitor thinks fit, and at least once in every three months, be visited by the inspector and an official visitor (Lunacy Act, 1890, sec.72)

Inspectors were selected by the Governor in Council. In this sense, the approval of the Lunacy Act 1890 did not just reinforce the safeguard over private patients, but it centralised the control over the local authorities.

Despite the differences between pauper and private patients, certification aimed to reinforce the central control of the management of lunacy. Public order was supposed to be preserved by a juridical apparatus with the dual function of avoiding cases of malafide in the private management of lunacy and reinforcing central control over pauper lunatics. The medical discourse offered technical support to this apparatus in the procedures of certification and in the management of the institutions, as the Lunacy Act required a medical practitioner to be the superintendent of any institution (Lunacy Act, 1890, sec.3; sec.50). In particular, one of the main functions of the medical professionals working in the institutions for lunatics was to keep a series of records on any patient admitted into the asylum (Lunacy Act, 1890, sec.8; sec.55).

The institutionalization of the public asylums in each county and the introduction of the license and register for the institutions for private patients resembled the "quadrillages" (Foucault, 2003, p.44) of the areas where patients were kept. Moreover, the law established a capillary structure of control branched off to all the single individuals involved in the apparatus from the families, through the patients, superintends, and local authorities with continual supervision of commission and organisms that were respectively under the management of the Secretary of State.

However, the family was the primary institution dealing with the care and "private repression" (Castel, 1979, p.22) of these individuals and, as such, it was an integral part of the system in the preservation of the public order. It was possible for a family to keep a patient in the house, but it was still regularly checked. Institutions for lunatics, by contrast, substituted the family (Foucault, 2006), when it became visible to the society that the individual required coercion. In this sense, it is interesting to notice that, although the system was built around lunatics, they were not the only subject of control, but only one of the elements of this hierarchical structure, as families, guardians and doctors were still checked through the use of records.

The will of the patient: from custody to treatment

The first rupture in the economy of power described in the previous subsection emerged in the period around WWI with the approvals of the Mental Deficiency Act, the Ministry of Health Act and the Mental Treatment Act. These three statements enabled the dismantling of many elements of the previous system, eliminating the division based on classes, consolidating this process of centralization of the management of mental illness started in 1890, changing the representation in the legal discourse of the person with mental illness, and, most importantly, enabling the medicalization of this matter. All these elements were central for the acceptance of the deinstitutionalization discourse.

The Mental Deficiency Act of 1913 was the result of the problematization of the indiscriminate institutionalization of patients that characterised the previous system. These critiques were not directed against the institutions for lunatics in themselves, but against the lack of proper services for a specific category of patients: the born idiots (Wormald, 1913). The Mental Defective Act 1913, in fact, created new specific institutions for this category and empowered the guardianship over all mental defectives (sec.30), in particular, those under the age of twenty-one (sec.1). This further division allowed the extension of the legal discourse "to defective persons not certified under the lunacy laws" (Wormald, 1913, p.1). This act was an essential condition for the formation of the deinstitutionalization

discourse in England in different ways. First of all, it allowed the blurring of the clear division between the private and public sphere that characterised the previous system. The Mental Defectives Act 1913, in fact, empowered the local authorities to supervise defectives while they were in their families without differences of social status and to make arrangements for them in institutions if needed (Sec.30). Secondly, it allowed a change in the representation of the mental defectives in relation to the concept of dangerousness. As seen, the Lunacy Acts dealt only with those cases that showed apparent signs of their unsoundness expressed through the purpose of committing a crime[24]. Their exclusion was a necessity not because of their mental illness but, as it was associated with dangerous conduct, for public order. The Mental Defective Act, by contrast, made any mental defective the object of the law, and it justified this shift with the potential dangerousness implied by their mental condition. In other words, dangerousness became an implicit condition of mental defection, as these subjects were "incapable of self-control... and were a source of lasting injury to the community" (Wormald, 1913, p.2). As a consequence of this shift in the representation of mental defectives, hospitalization was problematized as an inefficient strategy, favouring the extension of the control over all mental defectives starting from their families. The law empowered the guardianship over all mental defectives with the development of a network of social services and institutions to support the families and aimed to "[prevent] the degradation and ruin of the feeble-minded rather than by dealing with them after disaster has overtaken them" (Wormald, 1913, p.93). In this sense, the act was justified as "an important stage in the growth of the responsibility of the community of its weakest...members" (Wormald, 1913, p.vii). Thirdly, the law ratified the formation of a central authority dealing with this specific matter continuing the process of centralization of the main authorities (Mental Deficiency Act, 1913, secs.21-26) already started with the Lunacy Acts. This third element was even consolidated by the approval of the Ministry of Health Act 1919 that aimed "to establish a Ministry of Health to exercise in England and Wales powers with respect to Health and Local Government" (sec.21).

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[24] Suicide in this period was still considered a crime.

Health was acknowledged as a public problem and, as such, it became the object of policies at the national level. Lunacy and mental deficiency were included in this new department, as stated by the law: "all or any of the powers and duties of the Secretary of State under the enactments relating to lunacy and mental deficiency" (Ministry of Health Act, 1919, sec.2). These first two laws started an important transformation in the legal discourse on mental illness that was essential for the acceptance of the deinstitutionalization discourse, because they enabled a medicalization of mental illness, through the inclusion under the Minister of Health, and the extension of the control over all mental defectives. Moreover, the Mental Defective Act started a problematization of the hospital and of exclusion as an effective method for the management of deviant conduct, favouring the implementation of services in the community.

The Mental Defective Act of 1913 had as its main justification the "waste of national resources, both in actual money and human life well-being" (Wormald, 1913, p.1) due to the indiscriminate hospitalization of patients. In other words, this strategy was based on the idea that prevention was a more effective strategy than hospitalization, in particular for children, as asserted by Wormald (1913, p.viii), "very often such children will never need institutional treatment if these powers [of guardianship] be wisely exercised".

This problematization of the psychiatric hospital was in line with the criticisms made by social psychiatry in the 1920s and discussed in chapter IV. As seen, war neuroses allowed the diversification of the treatment of psychiatric patients on the basis of their grades of severity, blurring the strict division between insane and sane, which was at the core of the Lunacy Act 1890. In accordance with these elements, the previous English system of lunacy was further problematized by the Royal Commission on Lunacy, required by the Minister of Health in the 1920s. Lunacy acts were criticised as their original aim was to keep "pauper lunatics…safely locked up in some secure place" (Royal Commission, 1926, p.10). On the basis of the "advance of medical science" (Royal Commission, 1926, p.16), showing "that there [was] no clear line of demarcation between mental illness and physical

illness" (p.15), the report recommended a shift of the previous strategy with the following words: "the keynote of the past has been detention; the keynote of the future should be prevention and treatment" (Royal Commission, 1926, p.17). In particular, the Royal Commission questioned the procedures of certifications as "contrary to the accepted canons of preventive medicine" (1926, p.18), and recommended that their use "should be the last resort in treatment, not the pre-requisite of treatment" (Royal Commission, 1926, p.19), as it was in the previous system. In accordance with the medical approach proposed by the report on shell-shock for the management of soldiers' discipline, the Royal Commission (1926), rather than proposing new juridical procedures for the management of mental illness, recommended the improvement of the professional training of the staff working in these services, stressing that "mental science should receive more attention in the medical curriculum" (Royal Commission, 1926, p.116). In accordance with the psychiatric discourse illustrated in chapter IV, exclusion and segregation of all patients were problematized, as new psychiatric knowledge introduced the concept of prevention of the admission in the hospital for certain patients, such as those affected by neuroses.

The Mental Treatment Act 1930 contained most of the Royal Commission's recommendations. This law was characterised by the coexistence of multiple strategies at the core of the English deinstitutionalization discourse. First of all, this law formalised the medicalization of mental illness through the introduction of two new procedures for the admission of "voluntary patients" (Mental Treatment Bill, 1930, sec.1), and for "temporary treatment without certification" (Mental Treatment Bill, 1930, sec.2) made on the discretion of the doctors. The use of psychiatric hospitals was extended to any patient who required psychiatric treatment. Although this may seem inconsistent with the deinstitutionalization discourse, it enabled the transformation of the psychiatric hospital from a place of coercion and segregation, to a place of treatment and rehabilitation of the patient. This emphasis given to the medical treatment of mental illness was also stressed through the substitution of the term *asylum* with *psychiatric hospital.* Secondly, it allowed the centralization of the control of the management of mental illness

through the abolishment of the use of words such as "pauper" and "lunatics" from the public documents concerning people of "unsound mind" (Mental Treatment Act 1930, sec.21). The elimination of the connection between pauper and lunacy, in fact, enabled to separate the law concerning mental illness from the Poor Law. Finally, the Mental Treatment Act of 1930 ratified also the creation of a network of hospital services for the treatment, care and after-care (sec.6) supervised by the "Board of Control" provided by the central authority (sec.11), and the complete abolishment of workhouses for people affected by mental disorder (sec.20). These transformations favoured a process of diversification of the services for the treatment of mental illness, reducing the centrality of the psychiatric hospital while reinforcing the central authority.

It is important to stress that the legal procedures were still active, as the Mental Treatment Act was additional to the Lunacy Act. The coexistence of these two strategies, namely the medical and the juridical ones, was an essential condition for the formation of the deinstitutionalization discourse in England, as the preservation of certification as a legal practice was related to a specific representation of the patient affected by mental illness. In agreement with the representation of the individual affected by mental deficiency in the Mental Defective Act, certification was justified by "the special nature of the symptoms of mental illness" (Royal Commission, 1926, p.17). In other words, dangerousness became a symptom of mental illness, and it was strictly related to the ability of the individual to control him- or herself. As explained by the Royal Commission,

> No man can be a member of society without sacrificing some of his liberty. He is entitled to exercise his liberty of action in so far only as he does not thereby infringe the liberty of others. If he insists on exercising his liberty so as to cause danger to others he must suffer restraint. The price of liberty is conformity to the social order of conduct (1926, p.17).

Thus, certification was necessary when the capacity of control of the patient was completely subjugated to the mental illness. This rationale took the shape of a new division of the patients in relation to their procedures of admission, and patients

were split into voluntary and temporary patients without certification, and certified patients: while the first two groups were dealt with under the Mental Treatment Act, and their procedures of admission were administered by doctors, the latter was still under the Lunacy Act, and overseen by magistrates. Thus, certification still worked as a dividing practice, not between insane and sane, but on the basis of the "degrees of mental instability" (Royal Commission, 1926, p.18) of the patient that was defined by the will of the patient to collaborate with the treatment. To a certain extent, this strategy even consolidated the procedures of certification, as the inability of the patient to ask for a treatment worked as proof of the necessity of certifying him. Rather than reducing the application of certification, this shift allowed the extension of the system to a larger range of individuals on the basis of their diagnoses and the degree of severity of their illness, and the coexistence of the previous model of exclusion with a new model based on the normalisation of the patient through the application of a medical intervention (Foucault, 1995).

Mental health and community care: population coverage

The previous subsection illustrated some of the main conditions introduced during the 1920s and 1930s that were essential for the formation of the English deinstitutionalization discourse. First of all, it showed the process of medicalization of the management of psychiatric patients, and the transformation of dangerousness as an intrinsic feature of mental illness, rather than as a consequence of criminal behaviour. It also explained the process of centralization started by the English government in relation to the control of health. This subsection will describe the final rupture that led to the approval of the Mental Health Act in 1959.

In the 1950s, a new Royal Commission was required in relation to "the reorganization and expansion of the health and welfare services which took place under legislation passed in 1944-48" (Royal Commission, 1957, p.37). The report pointed out that after the abolition of the Poor Law, "the special needs of special groups [were] now met by suitable administrative arrangements under...wider general powers" (Royal Commission, 1957, p.37). In particular, the report was

referring to the fact that the majority of the services in the community for people affected by mental illness were provided by the National Health Service, which was created in 1946. These transformations consolidated the centralization of the management of the health and welfare services, reducing the local authorities' responsibilities. Moreover, they reinforced the medicalization of mental illness through the integration of psychiatric services into the NHS structure. However, the formation of the NHS, rather than just confirming the process of power centralization, created an essential rupture in the previous strategies on mental illness changing the *target* of the policies through the introduction of the concept of mental health. The approval of the National Health System Act, in fact, moved the object of the political intervention from being "the treatment of physical and mental defects" (Ministry of Health Act, 1919, sec.2) to becoming "the improvement of the physical and mental health of the People of England" (National Health System Act, 1946, sec.1).

This shift involved important transformations in the care of mental illness as it enabled the extension of the psychiatric services to the full population and the multiplication of the sites of care. First of all, this implied that the *target* of mental health services, rather than being only those individuals requiring treatments, was the full population, and secondly, these services were aiming to achieve a certain "*standard of care*" (Royal Commission, 1957, p.39), which was not limited to the treatment of the mental illness, but the achievement of mental health. The inclusion of the concept of mental health was strictly related to the tripartite structure of the NHS that included "hospital and specialist service", "health services" for prevention, care and after-care, and "general medical and dental services" (National Health Service Act, 1946). As a consequence, hospitals were no longer the main element of the health services; education and guidance became an integral part of a larger organization led by the Ministry of Health. Moreover, the extension of the target to the full population implied that these services were organised on a "functional basis, instead of according to the category of persons who were to receive them" (Royal Commission, 1957, p.16). This shift was an essential condition for the formation of the deinstitutionalization discourse, as it

moved the focus of mental health services from the insane to the whole population and from the hospital to other sites for the psychiatric practices.

The inclusion in the NHS impacted on the legal discourse not only in terms of the *target* of the law but also in the *standard* of care, which was defined by the Minister of Health. According to the *Report of the Committee on Social Workers in the Mental Health Services* (1951, p.6):

> The National Health Service Act of 1946 has had a decisive effect in bringing into prominence the need for extending non-medical services of many kinds in the broad realm of public health.

This affected the system concerned with mental illness as hospitals from being the main place for the treatment and management of insanity became only one element of the full structure, promoting the process of diversification partially started by the Mental Treatment Act. The royal commission introduced the concept of "community care" in relation to this multiplication of the sites of practice of mental health (Royal Commission, 1957, p.102). The report described community care as having two main types of services: one of prevention and support "which [were] not provided primarily in relation to mental disorder but may prevent difficulties" which caused them, and another one defined as "various forms of care", such as "special forms of education or training", "general advice and help", and "after-care" for discharged patients (Royal Commission, 1957, p.102). To a certain extent, community care was an intersectional space between illness and health aiming to harmonize the different institutions, which characterised the previous system (institutions and educational services for mental defectives, out-patient clinic and psychiatric hospitals) with the new mental health services provided by the NHS. This multiplication of the sites for the promotion of mental health coincided with the multiplication of the fields of psychiatry illustrated in the previous chapter. The new techniques developed during WWII, such as group therapies, and the rehabilitative services in the community, provided the tools to

justify the movement of the care outside of the hospital. Moreover, community care, as a new place for the prevention and control of mental illness, enabled the professionalization of spaces different from the hospitals, and the creation of new specialised figures, such as psychiatric nurses and social workers (Committee on Social Workers, 1951), working in the middle between institutions and the full population.

However, the royal commission was not just called in relation to the reorganization of the services for people affected by mental illness, but also "to inquire…into the existing law and administrative machinery governing the certification, detention…discharge and supervision of persons…suffering from mental illness" (Royal Commission, 1957, p.37) and to consider "the need for new legislation" (p.37). The inclusion of the mental health services in the NHS and the extension of the target to the entire population allowed a new problematization of the concept of dangerousness, and more specifically, it problematized the need for a "special mental health legislation" (Royal Commission, 1957, p.38). On one hand, the final report pointed out that after the validation of the mental health services as an "integral part of the present national health and welfare" (1957, p.38), there was no longer need of a special legislation, because the "standards of care" (Royal Commission, 1957, p.38) were now a responsibility of the Minister of Health and welfare authorities. On the other hand, it also recommended the need for an extraordinary legislation for psychiatric patients due to the fact that "mental disorder has special features which sometimes requires special measures" (Royal Commission, 1957, p.39), and as such, at times, the report acknowledged the need for a law regulating coercive power.

The Mental Health Act 1959, which ratified the implementation of deinstitutionalization in England, was the product of these recommendations. As seen in the first subsection, the initial English apparatus on mental disorders was characterised by the combination of strategies aiming for the complete exclusion of specific categories of individuals, who required "coercion" (Lunacy Act 1890,

sec.64). The approval of the Mental Health Act in 1959, by contrast, introduced a new strategy which had, as its object, the whole population. Illness, exclusion, rigidity, formalism, which were the main features of the previous systems, were problematized to give space to other concepts, such as health, promotion, flexibility and variety, which enabled the acceptance of new sites for the psychiatric practices in the community. However, it is important to stress that the Mental Health Act was still a "special legislation" (Royal Commission, 1957, p.39).

Although the report problematized and rejected most of the objects that characterised the previous laws, the Mental Health Act 1959 ratified the creation of three groups for legal and administrative purposes (sec.4) characterised by the "free movements of patients" (Royal Commission, 1957, p.42) among the various services. On the basis of this, patients could access any medical service, and this equalization among the groups was also applied to the procedures of safeguard for compulsory power. While the legal-psychiatric system of the 1930s provided certification only for individuals affected by mental illness under the Lunacy Act, but not for the mentally defective, the Mental Health Act 1959 abolished completely the procedures of certification with the repeal of the Lunacy Acts, but it extended the procedures of compulsory power to all patients. Thus, coercion was still active, but it was not aiming for the complete segregation and exclusion of individuals affected by mental illness. Rather, it was a strategy associated with the risk of danger implicit in mental illness.

ITALIAN DISCOURSE ON DEINSTITUTIONALIZATION

Manicomi and social order

First Rupture	1946 Carta Costituzionale
	1956 I Sentence Constitutional Court
	1968 Legge n. 132
	1968 Legge n. 431
Second Rupture	1968 Sentenza Corte Inconstituzionalita' art. Legge n. 36/1904
	1978 Legge 180
	1978 Legge 883
	sentenza sulla pericolosita'

Table 6- Ruptures in the Italian legal discourse

This section will look at the conditions and the formation of the Italian deinstitutionalization discourse, stressing the main differences from, and similarities with, the English one. Table 6 shows the main ruptures of the Italian legal discourse. As for the English discourse, the creation of the Italian discourse did not coincide exclusively with the regulations that ratified the closure of the psychiatric hospitals, but it was strictly related to the development of the Italian government. In order to illustrate these correlations, I will start to outline here the Italian system before the approval of L. 180/1979, which sanctioned the implementation of deinstitutionalization.

The first national law regulating psychiatric hospitals and mental illness was L. 36/1904, and it concerned exclusively:

> All persons affected by any cause of mental alienation, when they are dangerous to themselves or at risk of causing a public scandal and they cannot be conveniently guarded and cured in other places different from the manicomio (L. 36/1904, art.1).

Although the regulation that followed this law, R.D. 615/1909 *Regolamento sui Manicomi e sugli Alienati*, referred to any institution dealing with "any form of mental alienation" (Capo I, sec.1), the main function established by the law was a custodial and segregative one. This function was reflected by the criteria set by the regulation itself: the manicomio was expected to be "outside of the residential area" (R.D. 615/1909, capo 4a) and structured in a way that eliminated "any possibility of danger for the patient and the other individuals, and of public

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scandals" (R.D. 615/1909, capo 4d). This chief function was also stressed by the professionals involved in the procedures of admissions. Although L. 36/1904 expected the person asking for the admission of a patient to provide a medical certification, the main decision was made by the local authority (called *prefetto*). In case of emergency, it was also possible to admit a person without any medical certification (L. 36/1904, art.2).

The narrowness of the medical function of the manicomio was also reflected in the organization of the institution itself. The internal division in the units was based on the grade of dangerousness[25] of the patient, and the main duty of the nurses was of "surveillance" (R.D. 615/1909, art.22) rather than a medical one. According to R.D. 615/1909 art.23, nurses did not require any specific medical training, but only specific features: "nurses must be sturdily-built and healthy, in possession of a valid medical certification, and they must have good morals and good behaviour". Thus, nurses were expected to play a physical and a role model function, rather than a medical one.

On one hand, the Italian discourse just outlined was very similar to the English one before the 1930s. There was no law regulating the treatment of people affected by mental illness who were not considered dangerous to themselves and others. But complete "compulsory confinement" (Castle, 1991, p.284) of those individuals who were considered morally dangerous to the society, with a low expectation of rehabilitating them, was contemplated. On the other hand, L. 36/1904 differed from the Lunacy Act 1890 because it did not provide any form of safeguard for the individual admitted into the manicomio. While in the Lunacy Act 1890, the judge worked as controller of the medical decision, in the Italian law, the decisional

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[25] R.D. 615/1909 art. 4 stated that each psychiatric hospital should have separated units:

a) Separate units for patients under observation with one or more rooms for the mentally disturbed and dangerous ones;

b) Units where the patients can work, preferably in agricultural activities;

c) security units for the isolation of the dangerous patients (…)

d) Isolation units for those with contagious illnesses;

e) Special units for those under juridical observation;

f) a space for the observation, study and cure of the patients.

power was completely left to the local authority, and there were no other institutions in charge to confute that decision.

With the approval of the Codice Penale in 1930, called Codice Rocco[26], the custodial function of the psychiatric hospitals was further exacerbated with the inclusion of the manicomi in the list of the "safety measures" (art.215, c.p.p., 1930) introduced in the new penal system. The Codice Rocco, in fact, reformed the entire Italian penal system creating a new judicial model called: *sistema binario* ("double track system"), characterised by the coexistence of punishments and measures of safety. This subsection will focus mainly on the latter. According to Battaglini (1933), the editor of the Rivista Italiana di Diritto Penale during the 1930s:

> A 'measure of safety' is an administrative precaution that does not seek to settle a question of justice, but serves only as a defense of society against some danger arising from particular persons because of their abnormal subjective conditions (p.288).

In other words, safety measures were not necessarily related to a criminal act, but such people were sentenced in case a subject was defined as socially dangerous. The introduction of the concept of "social dangerousness" (art.203, c.p.p., 1930), as a legal status, was related to important transformations not just in the management of mental illness, but in the general management of crime and deviance in Italy. According to the Codice Rocco:

> A person is defined as a social danger, even if he is not imputable and not punishable…and it is probable that he is going to commit new acts recognised by the law as crimes (art.203, c.p.p., 1930).

With this definition, the new penal code problematized two principles that underpinned the previous Italian penal and judicial system: the notion of responsibility and the direct relationship between crime and punishment. The

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[26] The Codice Rocco was the penal code implemented during the Fascist era. The full title was Criminal Code and the Code of Criminal Procedure but it is known as Codice Rocco because of the name of Minister of justice who signed it.

rationale behind these problematisations was related to the approach to crime proposed by the Positive School of Criminology[27]. According to this school of thought, crime was considered a "social phenomenon" (Ferri, 1968, p.76): the result of "anthropological, telluric, and social" (Ferri, 1968, p.76) conditions. Thus, the assumption was that free will and morality should be excluded from the judicial process, because "crime has its natural causes, which lie outside of that mathematical point called the free will of the criminal" (Ferri, 1968, p.75). The Positive School emphasised the importance of studying the causes of crime in order to prevent it, rather than acting after the crime has been committed. In this sense, the aim of the judicial process was supposed to be transformed from being focused on the criminal act and the punishment, to the analysis of the factors that made the subject become a criminal. This scientific approach to criminals was inspired by the anthropological studies started by Lombroso[28], the founding father of the Positive School. However, Ferri (1968) stressed the importance of not limiting the studies to the physical traits:

  The anthropological factor…must not be restricted…to the study of the form
  of skull…but he [Lombroso] continued by also studying the brain and the
  other psychological conditions of the individual (p.77).

Therefore, the Italian psychiatric discourse in this period was characterised by a deterministic and biological approach[29] to the study of personality, mental illness, and deviance. In this sense, it is interesting to notice that the importance given to social factors was mainly aimed at classifying the different types of personality, rather than finding a treatment for mental illness. While science can help to identify such subjects, the Positive School's assumption was that "scientific therapeutics can do little for relapsed criminals" (Ferri, 1968, p.104) and the only remedy was their

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[27] Ferri, who was one of the father founders of this school, made the first draft of the new penal code in 1921. Although the Codice Rocco made important changes to the project of 1921, Ferri was still one of the members of the committee and the documents referred directly to his work.

[28] See Lombroso's studies such as Crime: its Causes and its Remedies and The Criminal Man

[29] See study on electroshock made by Cerletti in 1938 as an example of the main organic trend of Italian psychiatry.

permanent segregation. The concept of social dangerousness was the result of this approach that personified crime in the criminal[30].

In this context, mental illness was legally recognised as one of the features of social dangerousness and, as such, needed to be signalled and controlled. The preventive function of the *manicomi* was consolidated with the introduction of a penal record (c.p.p. 1930, art.602 n.2) for all the subjects, offenders and non-offenders, admitted into the *manicomi*. The incurable nature of mental illness minimized the rehabilitative function of these institutions. The impossibility of feeling the punishment, or changing the moral of these subjects, was one of the main assumptions of the positive school approach, and the one applied in the Codice Rocco, as stated in the manual:

> At times, the afflictive effect of the safety measures is not even felt by the person who is exposed to it, as happens for those affected by mental illness (Ministero della Giustizia e Affari Religiosi, 1929, p.246).

Although art.87 and 88 of the penal code still recognised the non-imputability of people affected by mental illness, or under the effect of drugs, or alcohol, who had committed a crime, if a subject was considered socially dangerous by the law, he was subject to safety measures that were aimed not at his treatment, but at his complete segregation and exclusion from society.

> The punishment supposes as necessary premise the imputability and guilt of the actor, while social dangerousness is sufficient for the application of the safety measures (Ministero della Giustizia e Affari Religiosi, 1929, p.246).

In this sense, it is interesting to notice that these measures were applied to any individual who was supposed to be a danger for the social order. Thus, admission to the manicomio was not limited to those affected by a mental disorder.

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[30] For more information on the impact of Ferri and the positive school in the definition of the safeguard measures worldwide during the 1930s see Cantor N. 1936, Measures of Social Defense in *Cornell Law Review,* I(22).

This criminalization of mental illness found its concretization in a new institution: the "manicomio giudiziario" (art.215, c.p.p., 1930)[31]. This institution was provided for those subjects, who had committed a crime, but they were not imputable because of insanity, and the admission of them was similar to a reduced sentence, as explained by the penal code:

> If for the crime committed the law ratified the death penalty or a life sentence, the minimum detention in a manicomio giudiziario [forensic hospital] is ten years (art.222, c.p.p., 1930).

It is important to notice that the code stated:

> In the case of the person admitted to a manicomio giudiziario, who must serve a detention sentence, his execution is prolonged because he is not discharged from the psychiatric hospital (art.222, c.p.p., 1930).

The punishment was added to the preventive measure with the consequent indefinite sentence of detention of the subject, even after the sentence was served. Thus, the manicomo giudiziario played both a punitive and a preventive function, becoming the institutional representation of the double track system.

Although the Codice Rocco ratified the division of the psychiatric patients between offenders and non-offenders with the creation of a new institution, this differentiation was only related to the grade of dangerousness. Insanity was legally considered as a characteristic of the criminal personality, and not an illness to be cured. This representation of the patient affected by mental illness coincided with the characteristics of the Moral monster (Foucault, 2003), which also resembled the figure at the heart of the English system during the Lunacy act 1890. On the other hand, it is important to stress that while this representation was even consolidated in Italy in 1930, in the same year, England approved the Mental Treatment Act that introduced the concept of treatability of mental disorders.

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[31] The term "Manicomio Giudiziario" was introduced for the first time in an Italian legal document in 1876. Until 1930, these institutions were units into the prisons with the function of managing criminals affected by mental illness after their imprisonment. For more Information see: Manacorda, A., 1981, Il Manicomio Giudiziario: Alcune Note per la Comprensione dei Problemi Attuali. In *Il Foro Italiano*, Vol. 104, 3, pp. 67/68-77/78

Prevention was a common concept of the two national political strategies: in both cases, the discourses concerning the psychiatric hospitals were related to the attempt to rationalise the procedures of social safeguarding from the deviants, favouring preventive measures over punishment. However, when the English government problematized the procedures of certification and segregation as inefficient measures for the management of mental illness, it started a process of medicalization of the management of mental illness and the psychiatric services. In Italy, by contrast, prevention took the form of a penal reform: social dangerousness was transformed into a permanent legal status, and it was included in the penal system as a tool to rationalise the preventive measures of segregation. The strategy of exclusion was also reinforced through admission procedures. These were not limited to the physical segregation of the individual within the manicomio but also annulled the individual, in the sense that their right to a private life, as well as their political rights, were removed.

These differences in the national legal discourses in the management of mental illness cannot be reduced to the differences concerning the psychiatric justification and the representations of mental illness, but it is essential also to notice another important difference concerning their political rationales. As seen, one of the problematisations in the English political strategy regarding mental illness concerned the safeguarding of individual liberty in the management of the property. In the Italian discourse of this period, by contrast, the Fascist political strategy rejected an overestimation of "the individual's legal protection" (Ministero della Giustizia e degli Affari Religiosi, 1929, p.16), giving the penal system the main function of safeguarding the state and the social order. The fascist ideology, in fact, prioritised the state and public order over individuals and over families, as clearly stated in the guide on the penal code[32].

Even though the two governments took two different political strategies for the management of mental illness, both countries shared a process of technologisation

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[32] The hierarchy of harm or danger of social harm was listed in the II Book of the Penal Code. At the first place were located the crimes against the State, the Public administration and the juridical administration; after any religious crime and the social order. The individual and the private property were placed in the last places.

of insanity in the 1930s. As seen, in England this took the shape of a medicalization of the whole system. In Italy, by contrast, this was formalised in the preventive measures: mental illness was one of the elements of social dangerousness and, as such, needed to be controlled, checked, and marginalised. The Codice Rocco introduced the possibility of scientifically assessing the grade of dangerousness of the subject on the basis of the individual's features and the acts committed by him[33]. In this sense, mental illness was not considered as a medical matter by the Italian political discourse, and it was completely excluded by the following health reform of 1933 (R.D. 1265/1933).

This system characterised the Italian discourse on mental illness until the 1960s. The next subsection will look at its initial dismantling in relation to the transformation of the government organization and the psychiatric discourse.

The Italian Republic, the Constitutional paper and the process of medicalization

As seen in the previous subsection, the Italian psychiatric institutions were a central element of the penal reform formulated during the Fascist regime. Manicomi were not just the place for the custody of individuals affected by mental illness, but their function of safeguarding the social order was extended to any subject who was considered socially dangerous. After WWII and the defeat of Fascism, Italy became a republic, and a Constitutional Paper was ratified in 1948. On the other hand, this was activated only in 1956, after the declaration of the Constitutional Court of the priority of the constitution over any other laws:

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[33] Art. 133 of the Penal Code defines the criteria for the definition of the severity of the crime. These were a mix of the crime features and the subject personal characteristics. The sentence of punishment or safety measures were defined on the basis of the following elements:

1. Nature, type, means, object, time, place and any other modalities of the action; 2. severity of the harm or danger caused to person affected by the crime (see footnote 24); 3. intensity of the harm and feeling of guilty.

Moreover, the judge must consider the capacity of the offender to commit a crime, based on:

1. motivation to commit a crime and the personality of the offender; 2. previous penal and criminal record, in general, the personal conduct and life of the offender before committing the crimes; 3. the contemporary or subsequent conduct; 4. personal, familiar and social life of the offender. (p.c.c., 1930, art. 133)

The assumption that the new institute of 'unconstitutionality' refers only to laws subsequent to the Constitution and previous ones cannot be accepted…The constitutional law, because of the intrinsic nature of the rigid Constitution, must prevail over the ordinary rules (Corte Cost. 1/1956).

The notion of unconstitutionality was included in the legal discourse as a tool to assess the previous legal system. Therefore laws were subjected to a process of corroboration on the basis of the new principles introduced by the constitution. This event was essential in formation of the deinstitutionalization discourse in Italy because it introduced a new idea of citizenship. According to the constitution, citizenship should include the principle of equality:

All citizens have the equal social dignity and are equal before the law…It is the duty of the Republic to remove those obstacles of an economic and social nature that, by the fact limiting the freedom and equality of the citizens[34] (Cost., art.3).

Moreover, in accordance with art.32 of the Italian Constitution (1947), "health" became a "fundamental right of the individual and as a collective interest". Consequently, in 1958 the Italian government approved the creation of the Ministry of Health (L. 296/1958), and health was acknowledged as a right of the whole population and as a duty of the government. Mental illness was included in this new ministry, and its management, from being exclusively a problem of public security, became a public health issue. This impacted on the authorities involved in the psychiatric hospitals' admission procedures: the prefetto was replaced by the Minister of Health and the local GP in the R.D. 615/1909. However, the penal code remained untouched, and the psychiatric hospital maintained its function of a safety measure. Moreover, any individual admitted in the psychiatric hospital was still subject to the subscription in the criminal record and the annulment of the

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[34] While previous texts were all translated by myself, for the text of the Italian constitution I have referred to this translation: Casonato, C., & Woelk, J. (Eds.). (2008). *The Constitution of the Italian Republic*. Trento: University of Trento

private and public rights. Thus, the main custodian function of the psychiatric hospital stayed untouched.

The problematisation of this psychiatric system and, in particular, of the manicomio started at the beginning of the 1960s with the Gorizia experiment illustrated in the previous chapter. As seen, during this struggle against the custodian function of the psychiatrist, a "new psychiatry based on the psychotherapeutic approach to the patient" (Basaglia, 2014, p.25) was opposed to "the old positivist scheme" (Basaglia, 2014, p.26) characterised by the traditional medical-patient relation. The "therapeutic community" was suggested as an "alternative to the institutional regression of the patients" (Basaglia, 2014, p.29), and the psychiatric hospital was problematised as it was a symbol of the positive psychiatric approach. Specifically, the new Italian psychiatric discourse was characterised by the complete refusal of the psychiatric institution, and it aimed for its complete elimination. As seen in chapter IV, the Gorizia experiment took the shape of a complete overthrow of the internal hierarchy of the institutions, the rejection of the medical status of institutional psychiatry, and the "liberation" (Pirella, 2014, p.32) of the patient from the institution.

The discourse originated from the Gorizia experience did not stay enclosed in the professional circle, but it also took the shape of documentaries and films aimed at humanizing the psychiatric patients in the public imagination and reporting the horrible living conditions of the patients in the manicomi[35]. As see, the Italian psychiatric discourse was not aiming only for the transformation of the psychiatric practices in the hospital, but also for the creation of "a public service accessible to all, able to break the exclusion of the patient from society through his institutional segregation" (Pirella and Casagrande, 2014, pp.182-183). This involvement of the population in the psychiatric discourse determined an increased interest by the

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[35] The documentaries listed in the previous note were characterised by a common style. The interviews of the patients were superimposed against the images or brief videos of patients tied to trees, beds and chairs, often without clothes, as was typical in the traditional psychiatric hospitals before the new psychiatric approaches.

politicians[36] allowing the inclusion of the psychiatric hospitals in the political discourse. As a consequence, psychiatric hospitals were even problematised during an institutional discourse by the Minister of Health in 1965 and likened to "nazi-lager"[37].

In 1968, the year of the publication of the report about the Gorizia experiment, the government approved two new laws: L. 132/1968 on *Enti Ospedalieri E Assistenza Ospedaliera* concerning the management of the hospital, and L. 431/1968 on *Provvidenza per l'Assistenza Psichiatrica*. It is important to note that the latter law concerning the psychiatric services was just a temporary law ("Legge stralcio") approved for the purpose of producing a complete reform as soon as possible.

In accordance with art. 32 of the Constitution, L. 132/1968 introduced in the Italian discourse the concept of the hospital as a public body aimed "to cure, defend the health and giving hygienic and sanitary education" (art.2) with no difference shown between economic or social status. This statement released the use of the hospitals to the full population "without the requirement of special documents and convention" (L. 132/1968, art.2). This was an innovation compared to the previous health structure that was based on a health insurance assistance system[38].

This reform was not limited to the legal discourse, but also influenced the levels of governance. One aim of the Constitution was to increase the decentralization of power, extending the participation in the definition of the norms[39]. For this reason, art. 116 of the constitution provided the creation of a new level of governance between the state and the local authorities: the Regions. Accordingly, L. 132/1968 enabled the formation of this new political institution, moving the hospitals from

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[36] According to Canosa (1979) in *Storia del manicomio in Italia dall'Unità a Oggi*, the Italian parliament discussed 5 different proposals for the reformation of the psychiatric hospital in the middle of the 1960s but none was approved until 1968.

[37] Nazi-Lager means Nazi Concentration Camp. For a full history of this analogy in Italy See Chapter 5: "Manicomio=Lager History and Politics of an Analogy" in Foot, J. (2014b). *La «Repubblica dei matti». Franco Basaglia e la psichiatria radicale in Italia, 1961-1978.* Milano, Italy: Feltrinelli

[38] In 1936, the fascist regime created a health system. Services were accessible on the basis of different professional categories. Thus, health services were unequally distributed according to social economic differences.

[39] See TITLE V - Regions, Provinces, Municipalities of the Italian Constitution

being under the control of the Provincie to the regional one. Psychiatric hospitals were included in this new public body, starting a process of medicalization of the legal discourse on mental illness. For the first time, L. 431/1968 acknowledged the medical function of the manicomio, as noticeable since the headline: on Provisions on Psychiatric Assistance (L. 431/1968). This was also supported by the professionals expected to work in the psychiatric hospital: psychiatrists, psychologists and GPs. The law stated that "the hospital must also have the appropriate personnel for the purpose of health and specialised social assistance" (L. 431/1968, art.2). This process of medicalization was also stressed through the introduction of the concept of "voluntary admission" (L. 431/1968, art.4). In accordance with the right to health, voluntary admissions enabled the accessibility to the psychiatric services to all patients asking voluntarily for their admission without being subjected to a permanent admission. Moreover, the law allowed the doctors to change the status of the patients compulsorily admitted to voluntary patients and the criminal record of the patients admitted to the psychiatric hospitals was completely abolished. Finally, the law provided the institution of new psychiatric services accessible to the population without the need for hospital admission, called as "Centri di Igiene Mentale"[40] (L. 431/1968, art.3). The law did not give any clear connotation to these services, but CIM enabled the extension of the psychiatric intervention outside of the psychiatric hospital's walls.

The actions ratified by L. 431/1968 signalled an important rupture in the Italian political strategy on mental illness. On the other hand, it is important to notice that these changes were just additional to L. 36/1904. Psychiatric hospitals and the medical staff maintained their custodial function as specified in the law:

> Until it would be not defined in a different way by another law, the norms concerning the juridical status [of the psychiatric hospitals and its staff]…The special regulation concerning each psychiatric hospital must maintain the mixed medical and administrative status for the enrolment of the staff (L. 431/1968, art.2)

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[40] Mental hygiene centres and commonly known as CIM.

This created the coexistence of two different strategies in the management of mental illness, a medical and a juridical one, that, to a certain extent, resembled the English discourse during the 1930s. On the other hand, there were some important differences between the two national discourses, both in the strategies applied, and the procedures, that characterised these systems.

As seen, the period after WWI saw the inclusion of the medical experts' voices in the English government documents. The problematisation of the previous insanity system and the transformation of the services were justified by the medical advancements, and the approval of the Mental Treatment Act was the result of the strict and reciprocal interrelation between the political strategy and the psychiatric discourse. The extension of psychiatric practices outside of the hospital and the introduction of voluntary and temporary treatments, in fact, reinforced the medical status of psychiatry, but it also supported the process of centralization of political power started by the English government. L. 431/1968, by contrast, was not the result of this combination, but rather a counter-manoeuvre to the struggle (Foucault, 1982) against the previous system started in the psychiatric hospital. Although the introduction of the voluntary service and the provision of a more accessible diagnostic centre (CIM) reinforced the medical status of the psychiatric hospitals, these were still recognised as a safety measures in the penal code. This was not the only contradiction that resulted in this system: the law, in fact, abolished the subscription in the penal record for the people admitted in the psychiatric hospital, but patients were still subjected to the elimination of their private and public rights.

This internal ambiguity of the Italian system was also reflected in the functions played by the authorities involved in it. According to L. 431/1968, it was expected that professionals working in the hospitals were specialised in the medical and social rehabilitation of mental illness, but they were still responsible for the detention of the patients. Moreover, while L. 321/1968 ratified the control of the hospitals to the regions, psychiatric hospitals, by contrast, were still a duty of the province, as the prisons.

While the law reinforced the medical status of the psychiatric hospitals and the psychiatrists, this just reinforced the justification of the custodial function of these institutions. Contrary to the Mental Treatment Act, the Italian law, in fact, did not provide out-patients services, but hospitals were still the only site of treatment. On the other hand, the inclusion of the psychiatric system in the national reform of the hospitals determined the increase of the power by the local authorities over these institutions, reducing the decisional power and autonomy of the director, who in the previous system had the complete control over the hospital. In this sense, it is interesting to notice how the Italian strategy was aimed to regain control over the psychiatric struggle.

The alliance between psychiatrists and magistrates: social dangerousness and manicomi

The 1960s signalled an important transformation in the relations of power that previously characterised the Italian political government. As seen, the Constitution ratified the centrality of the citizens[41] over the state and the decentralization of power between diverse levels of governance. Moreover, the psychiatric system was included under the management of Ministry of Health, transforming the representation of the patients affected by mental illness: from being a social danger to ostracize, they acquired also the status of citizens to be treated. However, the two representations coexisted in a unique system.

The Italian custodial management of alienation relied on the symbiosis of the legal and psychiatric discourses of the Positivist School. Chapter IV showed that the formation of a new psychiatric discourse and the problematisation of the manicomio originated by the refusal of a group of psychiatrists in Gorizia to be the custodians of the patients (Pirella in Basaglia, 2014 [1968]) keeping this collaboration between the legal and psychiatric system. L. 431/1968 was the result to this struggle and impacted on the previous economy of power in two ways: reinforcing the medical status of psychiatry, and allowing its extension to a larger

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[41] See also art.1 of the Constitution: *"All authority belongs to the people"* (original: La sovranità appartiene al popolo)

population, but also reducing its power into the psychiatric hospital. After this law, the status of the patient affected by mental illness was problematized again, but this time, in the legal discourse. As seen, L. 36/1906 was based on the rationale that the public order was more relevant than individual freedom, thus it did not provide any legal safeguard to the admission in the hospital. In 1968, a sentence of the Constitutional Court ratified the unconstitutionality of one article of L. 36/1904:

> The tribunal found that the art. 2 of L. 36/1904...violates the general rights of the individuals to the judicial protection of their own rights and interests, the right to the safeguard as intervention in the procedures and technical-legal assistance, and the limits imposed by the right of the human being that, for those subjects suspected of mental alienation, is placed in a condition of inferior compared to the condition of the person who makes the interdiction, for the proposal of measures of safeguard and accused of having committed a crime (Corte Const. 74/1968).

There are two elements in this statement that are important to stress: the authority that produced this statement and the representation of the patient affected by mental illness. This sentence against art.2 was made by the Constitutional Court that is an institution of the state[42] composed of magistrates. Thus, this statement was, to a certain extent, an internal attack against a decision made by the government itself. Although the new law, L. 431/1968 acknowledged the mental treatment as a right of any citizen with the inclusion of the voluntary treatment, it did not provide any forms of legal safeguarding to the compulsory admission of people affected by mental illness. In this sense, sentence 74 attacked also the latter law, as it refused the diversification of patients affected by mental illness in the legal treatment and acknowledged their right to receive a legal safeguard as all the other citizens. Moreover, this sentence separated the legal status of the person

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[42] *The constitutional court shall be composed of fifteen judges, a third nominated by the President of the Republic, a third by the Parliament in joint sitting and a third by the ordinary and administrative supreme courts* (Art. 135 Cost).

affected by mental illness by his medical condition. The right of the subject as a citizen was placed before the condition of mental alienation and consequently, the "right of the individual to the judicial protection" (Corte Const. 74/1968) prevailed over the safeguard of the social order.

This process of medicalization of the manicomi and the acknowledgement of the legal rights of the patient affected by mental illness like any other citizen by the magistrates enabled the separation of the legal and the psychiatric competences in the administration of mental illness. While in the English discourse, the legalistic and medical discretion approaches were represented as two opposite rationales, impacting on the classification of the patients and the procedures concerning compulsory power; in Italy, by contrast, this division allowed the formation of a new professional alliance. After the publication of *L'Istituzione Negata*, in fact, the Italian psychiatric discourse lived a process of politicization and the various psychiatric experiences organised themselves in a movement: Psichiatria Democratica (see chapter IV). A similar process was visible also in the legal discourse. In 1971, Magistratura Democratica[43] published *Per una Magistratura Democratica* that was, to some extent, their representative document. In this statement, they explained the concept of "giustizia di classe" as "an element of the ensemble of activities aimed to preserve the essential function of the state and of the capitalistic juridical order" (Accattatis et al., 1971, p.149).

The statement criticised both legal discourses applied during fascism and after the creation of the republic because the full juridical system was functional to maintain the economic relationships that characterised a capitalistic society. One of the main objects of this legal approach was the problematisation of the principles of "formal equality" of the law, ratifying that "all citizens are equal before the law" (Accattatis et al., 1971, p.157) and of "judicial neutrality". Formal equality was criticised because functional to maintain "bourgeois domination" (Accattatis et al., 1971,

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[43] Magistratura Democratica, (democratic magistrates) was the name given to the movement started in 1964 by a group of magistrates. It is important to notice the common epithet, namely Democratic, that was also used by the psychiatrists. For more information on the history of the movement: http://www.magistraturademocratica.it/mdem/storia.php

p.157). Magistratura Democratica stressed, in fact, the importance of considering the economic differences of status, which were excluded as irrelevant during the judicial process and promoted the importance of "supporting the lower classes, according to the constitution" (Accattatis et al., 1971, 166). Another central element that characterised the new Italian legal discourse was the strategy "to open up [the legal knowledge] to the outside world" (Accattatis et al., 1971, p.173). The main aim of the movement was to "share the juridical technical problem with the population" (Accattatis et al., 1971, p.173), in order to avoid their exclusion by knowledge and consequently by the political decision[44].

As is noticeable, the commonalities between the main elements of the Italian psychiatric discourse outlined in the previous chapter, and the legal discourse were numerous: a group of professionals rejected its function in the social system and decided to use its knowledge to give power to those who usually were the objects of the political strategies. Both professionals' movements applied Marxist theories in their own field with the aim to demolish the "bourgeois domination" (Accattatis et al., 1971, p.157; Jervis, 1977, p.130).

These movements found their common object of attack in psychiatric hospitals. While psychiatry rejected the manicomio from the perspective of the psychiatric theories and practices, the legal discourse had as the main object of resistance the legal structure that supported them. At the beginning of the 1970s, it was possible to notice the multiplication of statements in the legal discourse having as objects L. 36/1904, the double track system, the "situazioni giuridiche sospese"[45]

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[44] Magistratura Democratica supported different social causes that led to the restructuration of the full Italian legal and social system: the worker statute (1970), law to legalise abortion (1978), differential classes in the school (1971).

[45] Situazioni Giuridiche sospese can be translated as "suspended legal situation". This concept has been used for those legal conditions concerning:

*1) the condition of a suspended penal process (…) in relation to a mental illness occurred to a defendant; 2) the condition of the suspension of a sentence of punishment to an offender (…) in relation to the occurrence of a mental illness; 3) to the situation of suspension of a measure of safety sentence (…) to a person who is already sentenced of detention, because of mental illness. (*Anynomus, 1974, p.568)

 With this term were defined those sentences that were left without any judgements, with the consequence that offenders affected by mental illness were segregated in the manicomi giudiziari without a deadline or any further process, without considering their crime. This was due to the fact that the penal code determined only

(Anonymous, 1974, p.568) and the manicomio as a safety measure. As for the psychiatric discourse, which revealed the living conditions of the manicomi, magistrates aimed to shed a light on the real reasons that "continue to preserve a law [L. 36/1904] in spite of the scandals and the complaints" (Anonymous, 1974, p.568). The legal discourse defined the therapeutic function of the manicomi, which was introduced by L. 431/1968, as a "grotesque farce" (Ambrosini and Ceccarelli Pulitanò, 1972, p.579). Magistratura Democratica pointed out that L. 36/1904 on manicomi never referred to cure and it was characterised by the complete absence of medical language. Manicomi were associated with prison and refused because of their "repressive aim" (Ambrosini and Ceccarelli Pulitanò, 1972, p.579).

"The guiding principles of L. 36/1904 and its regulation" were problematized because they were the one of "social prevention and defence" and used "social exclusion" as a weapon against "those who were defined as undesirable" (Ambrosini and Ceccarelli Pulitanò, 1972, p.579), or dangerous. As stated in this quote: "what is defined as ill coincides with everything that the social organization defines from time to time dangerous for its order" (Basaglia, 1982 [1979], p.448). The notion of social dangerousness was recognised by both discourses as the main rationale of the psychiatric institutions and the juridical management of mental illness. Thus, magistrates embraced the constitutional paper in order to dismantle the full preventive apparatuses. In 1971, for the first time, a sentence of the constitutional court ratified the unconstitutionality of one article of the penal code concerning social dangerousness[46] (Con. Court Sent. 1, 1971). These attacks led to the reintroduction of a new law concerning the psychiatric hospital as an object of the political discourse.

These struggles took the shape of a new law in 1978, namely L. 180/1978, which ratified the legal beginning of the process of deinstitutionalization in Italy. This law was the Italian corresponding legal document of the Mental Health Act 1959 but

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the minimum and not the maximum of the duration of the sentence of safety measure generating what was defined as a "*safety life sentence*" (Anonymous, 1974, p.568).

[46] Three other sentences declared the unconstitutionality of the notion of social dangerousness (Corte Const. 139/1982; 249/1983; 1102/1988) until the complete abolishment of the article in the Penal code.

they were characterised by three differences. First of all, the English law was the visible sign of the strict interrelation between the national political strategies of the centralization of the national health population and psychiatric knowledge developed in WWII; the Italian one, by contrast, was determined by the coincidence of the attacks made the legal and psychiatric discourses.

The second important difference concerned the contents of the laws. The mental health act ratified the creation of a mental health structure consistent with the one of the NHS, based on hospital, primary and social care. The Italian law, by contrast, ratified the complete abolishment of any psychiatric hospital:

> It is in any case forbidden to build new psychiatric hospitals; it is forbidden to utilize those already existing as specialized psychiatric divisions of general hospitals; it is also forbidden to create psychiatric sections or divisions in general hospitals and to utilize as such psychiatric sections or divisions or neurological sections or neuropsychiatric sections (L. 180/1978, art.7).

Moreover, while the English laws signed a new division in the patient, L. 180/1978 eliminating any difference between mental and physical patients through the removal of the concept of social dangerousness by the law. As explained by Basaglia in a paper on the new Italian law: "mental illness is not defined anymore as socially dangerous…this justifies the abolishment of any form of psychiatric hospitals" (1979 [1982], p.463). As a consequence, the preventive strategy applied in the management of mental illness was abandoned.

The third central element, which was strictly connected with the previous one, was the complete elimination of any special law concerning mental illness. With the approval of L. 833/1978 on the national health system, L. 180/1978 was absorbed in this general health law, with the complete inclusion of mental illness among the general health system. While in the English context, the medicalization of the management of mental illness and the extension of the psychiatric practices to the full population maintained the division between the subjects affected by mental

illness because of their special feature; the Italian deinstitutionalization discourse aimed to abolish any institutional or legal element of differentiation.

These differences in the national legal documents that regulated the implementation of the deinstitutionalization in Italy and England was strictly connected to the conditions that allowed their acceptance. While in England the Mental Health Act was part of a general strategy of rationalization and centralization of the government and, in fact, a great emphasis was given to the efficiency of the system, the approval of L. 180/1978, and its following absorption in L. 833/1978, was the representation of a struggle against a system that was based on the annulation and exclusion of any individual who was found to be a danger for the state. The complete abolishment of the psychiatric hospitals, the rejection of a special law for mental illness and the elimination of the concept of social dangerousness were all part of the attempt to dismantling the previous system and establish a new one based on an equal distribution of power among all citizens.

Conclusion

The chapter has illustrated the differences in the conditions that enabled the approval of the acts, which ratified the implementation of deinstitutionalization in Italy and in England. It showed that L. 180/1978 and the Mental Health act 1959 were the results of very different problematisations and rationales that led to the definition of heterogeneous implementations. These were illustrated on the basis of the relation between the transformations of psychiatric knowledge, legal discourses, and political strategies.

In particular, the data confirms two important elements stressed by the previous chapter: the relativity of psychiatric knowledge in terms of contents, and its relativity in the functions played in the national economies of power. While the previous chapter stressed how the national conditions allowed the formation of two psychiatric discourses with different objects, and styles, this gave a major emphasis on the possible functions played by knowledge. Contrary to the explanations given by Scull (1986) on decarceration, or by Jones (1993) in relation

to the acceptance of hospital reduction, this chapter showed that knowledge is not necessarily dominated, selected, and conditioned by one class, or dominant groups, but rather it can play different functions in relation to the specific economy in which it is included. As seen, while in England, psychiatric knowledge was applied to justify a political strategy decided on the institutional level, in Italy, by contrast, knowledge, and its re-appropriation from the base, played the function to overthrow the decisions made on the institutional level. The chapter also showed that this relativity in the function played by knowledge in the definition of political strategies is not limited to the national differences, but it changes also during the time. In the Italian case, for instance, psychiatric knowledge was used as support of the legal discourse by the Fascism, while during the 1960s, psychiatric knowledge started the process of rejection of the institutional organization to which it was intrinsically linked.

In this sense, this chapter confirmed the conclusion of the previous one, stressing the unproductivity of approaches looking for a univocal comprehensive model to investigate deinstitutionalization. The comparison illustrated the importance to not explain national differences on deinstitutionalization as due to simplistic, and broad, concepts, such as culture, and political context. These monolithic concepts, by contrast, need to be challenged as they can provide important clarifications on the differences in the national implementations. Finally, the analysis in this chapter, extending the attention on the legal discourse and government formation, enabled also to overcome the contrasting analysis of deinstitutionalisation, which characterised the previous studies, such as medical progress, and advancement in human rights, opposite to needs of capitalism. The analysis of the relationship between national governments, legal and psychiatric discourses enabled to show multiple relations of power that were entangled with specific conditions of the national and historical context, such as in the Italian legal discourse on mental illness, which was strongly marked by the fascism.

The attention, given by chapters IV and V, on the national validation of psychiatric knowledge will be further analysed in the next chapter. Chapter VI will focus on the

formation of the national evaluative discourses to show how these impacted on the problematization of the psychiatric hospitals, and in the transformation of the national discourses on deinstitutionalization after the approval of the laws.

CHAPTER VI: THE FORMATION OF NATIONAL AND INTERNATIONAL EVALUATIVE DISCOURSES OF DEINSTITUTIONALIZATION

Introduction

Chapters IV and V have illustrated respectively the specific social, historical and political conditions that enabled the formation and acceptance of the national psychiatric discourses in England and in Italy, and the problematizations that led to the approval of the Mental Health Act 1959 and L. 180/1978. This was achieved by looking at a wide range of documents from various sources, such as official reports, medical journals, and documentaries. This chapter, by contrast, will focus in detail on reports and evaluative studies produced by the experts in the field of psychiatric services in the two countries. As seen in chapter II, psychiatric hospitals and services in the community have been the objects of various assessments and observations on the national and international levels. This chapter aims to analyse the emergence of these evaluative discourses.

The assumption underpinning this investigation is that evaluative studies express the rationalities related to the implementation of deinstitutionalization policies and practices (Dean, 2010). Reports and evaluations are, in fact, generally designed to review the outcomes of practices and policy implementation; their main objective is to assess whether the consequences of specific procedures fulfil the expectations that were placed on them. However, they are not external to the discourses at the basis of the practices they seek to assess, and, as such, they follow the same rules. For this reason, this chapter will examine them not in order to validate or compare their results, but as a further element of the national discourses concerning the introduction of people affected by mental illness in the community. They will be considered not just as tools aiming to measure the efficacy or validity of a particular practice, but in relation to the functions they played in the consolidation of the regime of practices established during the processes of normalization of the care of mental illness in the community outlined in the previous chapters. In other words, these assessments will be investigated as the visible elements of the notions and

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expectations that characterised the national discourses on the care of the patients affected by mental illness in the community. I will question the way how such practices were problematized, and what type of knowledge these investigations were aimed to produce, or validate.

To a certain extent, this chapter cuts across the issues discussed in the previously, as it aims to further stress the national differences in the acceptance and implementation of deinstitutionalization in England and in Italy. If from one side, evaluations will be analysed as an element of the whole process of formation of the deinstitutionalization discourse in both countries. On the other, these assessments did not only work on the validation of the discourses on deinstitutionalization, but they also impacted on its formation. In other words, they enabled further problematisations of the previous strategies and procedures, reinforcing or invalidating old beliefs and including new assumptions, expectations, values and rationalities. For this reason, this chapter differs from the others, as it will include also documents produced after the approval of the national deinstitutionalization laws to investigate these transformations.

Starting from this basis, this chapter will analyse the reports and assessments produced during the three main ruptures in the formation of the deinstitutionalization discourse: the threshold of the social psychiatric discourses in England and in Italy, the implementation of the Mental Health Act in 1959 and L. 180/1978, and the acknowledgment of deinstitutionalization as an "international fact" (Goldman et al., 1982, p.153). Specifically, the first section will examine the documents that reported the English and Italian therapeutic communities as psychiatric practices before the deinstitutionalization policies were implemented. The second section will focus on the national evaluative studies during the first phase of implementation after the Mental Health Act 1959 and L. 180/1978. The third one will look at the international debate that developed in relation to the different laws and implementation of the mental health policies, in Italy and in England.

REPORTS ON THE THERAPEUTIC COMMUNITY EXPERIENCES: A CONFRONTATION

Before the implementation of the deinstitutionalization policies, the English and Italian psychiatric discourses were linked by a common object: the therapeutic community. As seen in chapter IV, this practice was a central element in the formation of both national social psychiatry discourses but, despite the explicit relation between the Gorizia's experiment and Maxwell Jones' therapeutic community at Belmont, they were based on very different assumptions. This section will explore the reports produced during the two experiences in order to show these differences in more detail, focusing on the strategies that characterised them and how they were related to the acceptance of the national deinstitutionalization discourses.

In order to achieve this aim, four statements will be analysed: *Social Psychiatry*, *Cos'è la Psichiatria?*, *Community as Doctor,* and *L'Istituzione Negata* (see Table 7)*.* Before analysing the contents, it is important to point out that I have selected these documents because they both reported the experiences of the first national therapeutic communities, namely the Belmont hospital in England and the Gorizia hospital in Italy. This common object of comparison enabled me to stress the differences in the expectations of these practices in relation to the formation of the national social psychiatric discourses. However, the main subject of investigation of this section will not be their object, but the function that these documents had in the validation of the deinstitutionalization discourses and in the formation of the evaluative discourse. As practices that preceded the implementation of the national deinstitutionalization policies[47], their reports worked as essential preconditions of the evaluative studies produced during the implementation phase.

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[47] Although *Community as Doctor* was published in 1960, thus, after the approval of the Mental Health Act 1959, the research was conducted in the period included between 1953-7.

This comparison will not be limited to cross-national differences. The reports under analysis were produced at two different historical moments[48] of the therapeutic community in England and in Italy. This will also allow consideration of the historical transformations within the same country.

The Belmont Unit: a social experiment

The English reports on the therapeutic community at the Belmont Unit shared as a common aim "to study and develop community methods of treatment" (Jones, 1952, p.xiii). They were produced at two different historical moments: *Social Psychiatry* was reporting the first experience of therapeutic community, while *Community as a Doctor* was written in a period when this method was already an accepted practice in England. However, their broad function was to outline a uniform and standardised model of psychiatric intervention doable in every hospital treating neurotic patients.

Social Psychiatry described the Belmont Unit as a proper "social experiment" (Jones, 1952, p.xviii) aimed at the "social adjustment" (Pomryn, 1952, p.85) of the patients through the re-creation of the community's social dynamics in the psychiatric hospital setting. Although the foundation of this method was, to a certain extent, inconsistent with the general discourse of deinstitutionalization, as it was attempting to renew the function of psychiatric hospitals from being the place of "end results" (Anonymous, 1931, p.81) to becoming a rehabilitative one, it was an important event in the acceptance of the movement of psychiatric care in two ways. First of all, it was essential for

Table 7- English and Italian reports- therapeutic community

English Therapeutic community reports	1952 - Social Psychiatry. A study of Therapeutic community
	1960- Community as Doctor. New perspectives on a therapeutic community
Italian Therapeutic community reports	1967 - Cos'e' la Psichiatria?
	1968- L'istituzione Negata. Rapporto da un ospedale psichiatrico

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[48] As seen in the previous chapters, the 1950s signalled in England the development of the community care discourse and in Italy, 1968 was an important year for the transformation of the legal, political and psychiatric discourse concerning the manicomio.

validation of social psychiatry, as the therapeutic community was "(one of the) earliest…attempts" (Rapoport, 1960, p.10) of rehabilitating psychiatric patients to the life in the community. Secondly, it introduced important elements for the formation of the evaluative discourse on deinstitutionalization. Moreover, this first report was the perfect representation of the English relations between knowledge and political strategy, as it was funded by the minister of work in order to support the political strategy of full employment (see Chapter IV). In the following paragraphs, I will focus on the former elements, as the latter will be discussed in the next section dedicated to the English context.

As clearly indicated by the title of the report, *Social Psychiatry* was not only seeking to prove the effectiveness of the results obtained by this first experience of the therapeutic community, but the general approach that characterised social psychiatry. As explained by Jones (1952),

> Our findings appear to justify the conclusion that it is possible to change social attitudes in relatively desocialized patients with severe character disorders, provided they are treated together in a therapeutic community (p.156).

The underpinning rationale of this new psychiatric practice was the capacity of experts to change the subject: treating mental illness and readjusting individuals to the social life. In this sense, the reports made a central contribution to the validation of the English social psychiatric discourse after WWII, as they were confirming the main elements outlined in chapter IV, such as the social dimension of mental illness and the possibility to rehabilitate individuals affected by neuroses. As seen in chapter IV, social psychiatry was characterised by a diagnostic and therapeutic approach that differed from the medical one applied by traditional psychiatry. The lack of observability of the symptom, the impossibility to find the cause of the illness in the body, and the use of alternative forms of treatment, such as the analysis of dreams, challenged the medical basis that gave to psychiatry the status of a scientific discipline. This report represented an essential event in the

acceptance of social psychiatry as a discipline, not just because it assessed a new practice, but because it validated the efficacy of this new psychiatric paradigm.

According to the idea of the experiment, the report described a "severe stage-by-stage appraisal" (Jones, 1952, p.vii) in which each element concerning the therapeutic community life was described meticulously, from the hospital organisation to the "record" (Pomryn, 1952, p.90) of the cases, the "follow-up results" (Jones, 1952, p.48), and the result of the treatments. All the "techniques" applied in the unit, such as "meetings", "psychotherapy" (Jones, 1952, p.59), and "psychodrama" (Jones, 1952, p.63), were illustrated. The advantages and disadvantages of their applications were listed. In other words, the report tried to define the possible difficulties related to these procedures, how to apply them, and the role played by the staff, in order to make the hospital work in the best way:

> The first essential [need of a neurosis centre] would appear to be that the trained staff working in such a centre should have a clear understanding of their various roles, and feel competent to meet them (Jones, 1952, p.55).

Training was a central element of the English document. The report sought to define general guidelines for the application of this method by the next generation of practitioners. In line with this, it provided practical knowledge for the application of practices and procedures that differed from those applied in psychiatric hospitals prior to the appearance of the therapeutic community. It is essential to notice two different but complementary elements of the strategy that underlies these documents: while demonstrating that this method was able to readjust dysfunctional individuals to social life, the report was also *adjusting* the psychiatric practices, which were applied until now in the psychiatric hospitals, validating a different approach to mental illness.

In order to illustrate the efficacy and validity of the therapeutic community, the document was characterised by a very specific language, with the use of statistics and quantitative variables. As a social experiment, the therapeutic community, presupposed the possibility to keep under control all the social variables working in the hospital setting. This was a further element of validation for the social psychiatric discourse, as, at a moment when psychiatry

was losing control over the body, which was a medical dominion, it was extending its control over the social dimension (see chapter IV). Social variables were quantified in order to make them calculable and manipulable, like any other variable in a traditional experimental setting. Thus, as shown by the table below, drawn from the *Community as Doctor* report, previously descriptive categories such as the patients' "personality factors" (Rapoport, 1967, p.189-190), were now expressed in quantitative forms to allow supposedly more scientific measurements

Table 8- (Rapoport, 1967, p.189)

TABLE 12	ADJUSTED UNIT IMPROVEMENT OF DIAGNOSTIC GROUPS							
	Psychotic		PD Weak		PD Strong		Neurotic	
	No.	%	No.	%	No.	%	No.	%
Imp.	4	25	37	45	40	75	10	77
Not. Imp.	12	75	46	55	13	25	3	23
Totals:	(16)	100	(83)	100	(53)	100	(13)	100

$$\chi^2 = 20\cdot1445, 3 \text{ d.f.}, p < \cdot0005$$

in differences before and after the treatment. It is also interesting to notice that these factors were not expressed individually but in relation to the whole unit.

In this attempt to establish a "practical method of seeking...common elements" aimed to build "some form of factor analysis" (Jones, 1952, p.114), the first report worked as an essential precondition for the formation of the English evaluative discourse. The creation of a quantitative method of evaluation to allow the control of individual variables in a social setting was something innovative in the psychiatric discourse and a central element of the second report. While the former English report was produced by the same professional working at the Belmont Unit, a

psychiatrist, the second, by contrast, was produced by an external expert who aimed to describe this method "from a social science viewpoint" (Rapoport, 1967, p.10). As explained by Maxwell Jones, in the Introductory chapter of *Community as a doctor*:

> Dr Rapoport was on his own without other research assistance. He spent this year in familiarizing himself with the whole structure…He also sought to view the staff as objectively as possible (Jones, 1967, p.I).

This second English report was not just aiming for "the refinement and testing of hypotheses" (Rapoport, 1967, p.10) related to the therapeutic community as a method of treatment, but sought also to establish "ways of translating theoretical insights into practical programmes" and "implement, test, and revise the idea" (Rapoport, 1967, p.11) that underpinned the therapeutic community treatment. While the former report gave more emphasis to the indication for staff (psychiatrists and nurses), with the aim to offer guidelines for future practitioners, the latter was the result of the application of new expertise and methods of observation. *Community as doctor* validated the existence of a new discipline operating alongside the psychiatric one and focused on the investigation of group dynamics, rather than on the individual. This science, rather than concentrating only on the therapeutic and rehabilitative dimension of the community therapy, placed greater emphasis on the "social organization of the Belmont Social Rehabilitation Unit" (Rapoport, 1967, p.14). Individuals were grouped on the basis of individual characteristics such as sex, gender, marital status, social background, and these features were after compared in relation to the level of adjustment of the unit, as shown in Table 9.

TABLE IO ADJUSTED UNIT IMPROVEMENT OF MARITAL GROUPS					
	Single		*Div.-Sep.*		*Married*
	No.	%	No.	%	No.	%
Imp.	54	51	10	59	30	65
Not Imp.	51	49	7	41	16	35
Totals:	(105)	100	(17)	100	(46)	100

$$\chi^2 = 2\cdot5298, \text{ 2 d.f., } p > \cdot05$$

The report illustrated "patterns of patient reactions" (Rapoport, 1967, p.169) to the professionals, to other patients using quantitative data. In other words, there was a displacement of the scientific language to the analysis of the social dimension. Moreover, the information collected in the construction of these patterns were not limited to the hospital setting and the individual rehabilitation but included also the social life and values of the patients before their admission. Thus, it was possible to notice a shift in the object of the study, but also in the practice itself, from the individual to the entire social environment, which was consistent with the strategies of *externalization* and *demedicalization* illustrated in chapter IV. The elaboration of these elements would prove essential for the formation of the evaluative discourse that will be discussed in the next English section.

The Gorizia Psychiatric Hospital: facing the internal contradictions

Cos'é la Psichiatria? and *L'istituzione Negata* were two essential texts in the formation of the deinstitutionalization discourse in Italy as seen in chapter IV. They were published in a short period of time (see Table 7), by the same authors and, to a certain extent, the second was a sequel to the first, as they described the full experience of the therapeutic community in Gorizia since its beginning in 1962. The aim of these documents was not just to describe the first Italian experience of a therapeutic community, but also to verify the therapeutic value of any psychiatric practices conducted in the institutional settings (manicomi). As explained by

Basaglia, "[the reports were looking at] the global meaning of such organization and the functions played by the different professionals [working in it]" (2014a, p.19). As in the English reports, in particular the second one, attention was paid to the whole social organization of the hospital. However, rather than looking for assessing a specific method, these documents were the result of a larger analysis of the manicomi, which aimed to show the "real" (Jervis and Schittar, 2014, p.187) social function of psychiatric hospitals. In order to achieve this aim, these documents were characterised by features very different from those of the English ones. First of all, they were based on a continual "self-critique" (Schittar, 2014, p.169) of the psychiatric hospital, rather than on quantitative outcomes. Secondly, therapeutic community had a different meaning. Finally, the Italian reports were not characterised by a scientific/academic style and language. I will discuss these differences in depth while seeking to illustrate how these documents contributed to the acceptance of the Italian deinstitutionalization discourse.

When talking about self-critique, the Italian reports refer to the critical stance applied by the authors of the reports toward any institutional setting, more specifically, the psychiatric one, both as a therapeutic setting and as a social organization. The standpoint of the authors was that psychiatric hospitals were not curative places. As explained by Jervis and Schittar (2014),

> [The report] examines the forms in which the implicit roles are taken in these relations that formed the [institutional] social systems. Thus, it is aimed in the first place to the organizations that…collect the majorities of those subjects who have been labelled as insane (p.186).

The Italian reports were inquiring into the role played by all the subjects involved in the psychiatric institutions. The underpinning assumption of these analyses was that these roles were dictated by the institution itself and, as such, they were taken for granted. Thus, the Italian reports were aiming to problematize a certain system, rather than showing results or offering solutions. As seen in chapter IV, the birth of the new psychiatric discourse in Italy was the result of the refusal of a group of professionals to passively accept their mandate in the psychiatric hospital, and

these documents were the description of the system they were rejecting. It included a series of reflections on the social processes involved in the psychiatric practices, from the moment when a professional started to work in the hospital until the moment of admission and treatment of a patient, with specific attention paid to the formation of the social roles and hierarchy established in them.

This distinctive element of the Italian report was strictly related also to the specific meaning that was given to the therapeutic community. According to the Italian reports, every hospital is a community and, as such, is characterised by a social system. However, this becomes a "therapeutic community" only when it starts "to face its internal contradictions" (Basaglia, 2014a, p.27), and this happens only through the activation of the aforementioned process of self-reflection. As seen, the English reports studied the therapeutic community as a social experiment aiming for the social readjustment of the patients. The therapeutic community in the Italian discourse, by contrast, was an experiment aiming for the "liberation" of the patients (Jervis and Schittar, 2014, p.193) (see chapter IV), and this was achievable only through the "examination of the present conditions" (Jervis and Schittar, 2014, p.194) of the individuals involved in this organization. Rather than being a psychiatric and curative practice, the therapeutic community was described as the place for this reflection.

The reports were to a certain extent the logbooks of Gorizia's experience. They included the transcriptions of the various meetings between professionals and patients or personal reflections on the impact of the psychiatric hospitals on the life of the person interviewed. While the English reports applied the therapeutic community as a way of updating the function of the psychiatric hospital, the aim of the Italian reports was to show the reflective and dialectical process that had led to the rejection of the psychiatric hospitals as a place of treatment. This argument was not supported by any quantitative data or statistics. Neither patients nor staff was the objects of any observation of measurement by external experts. Instead, they were active subjects of this process of analysis of their own roles in the psychiatric hospital. Accordingly, the reflections contained in the reports were not just made

by the professionals working in the hospitals, but they included also the patients' reflections.

> This is the problem that a group of psychiatric patients, doctors, nurses, psychologists and administrators, all working in a psychiatric institution, has tried to address [with this report] (Jervis and Schittar, 2014, p.186).

Patients, as individuals involved in the social structure of the psychiatric hospitals, were an integral part of the reflection, and their voices were included in the reports with a function similar to that of the professionals.

Rather than speaking through diagnoses and numbers, the report aimed to support the validity of its discourse against the psychiatric institutions with the direct experiences of patients and doctors. The reports illustrated the violence to which patients were subjected in order to raise awareness also among people outside of them of the oppressive function played by the psychiatric hospitals. The following quotes are just a few examples of this style:

> Because before, those who were here begged to die. When one patient died, a bell used to ring…and we all used to say: I wish it was me because I cannot deal anymore with this life in this place (one patient, in Vason, 2014, p.15)

> In the psychiatric hospitals, 'distressed' psychiatric patients were subject to 'choking'…their heads were covered with a bedsheet, which was often wet so that they were unable to breathe (Basaglia, 2014b, p.114).

Contrary to the English documents, the Italian ones were not using scientific language. Their style was informal, free of specialist terms. In line with the process of rejection of norms and medical knowledge illustrated in chapter IV, the use of classification and standards, including diagnosis and medical terms, were rejected. The Italian reports were not produced with the aim of offering guideline or new know-how for the professionals working with mental illness. Nor were they looking for the validation of their work from other experts. As explained by Basaglia (2014b):

It's too easy for the psychiatric establishment to define our work as lacking in credibility and scientific respectability. We take this as a compliment because in the end, it places us side by side with…psychiatric patients and excluded people (p.13).

This emphasis on the oppressive function of the institutions was the main feature and point of difference between the two Italian reports. Although there was already attention on the role played by politics in the institutional arrangement, the main focus of the former report was on psychiatry and the manicomio. The second report, by contrast, extended this analysis to society as a whole. However, this extension to the social dimension outside of the hospital was different from the externalisation in England because it was not linked to the social background of the patients but to any other institutions in the community. As stated by Basaglia,

Any scientific investigation on mental illness is possible in the psychiatric hospital only after the elimination of any sub-structure related to the violence of the institution…of the family, and…of all the institutions into the society (2014b, p.145).

While the first report reported the therapeutic community experience in Gorizia, as an analysis of the psychiatric hospital in relation to its therapeutic function, the latter document problematized the therapeutic community itself. This method was rejected like any other method applied into the psychiatric institution. After their experiment in Gorizia, in fact, *L'Istituzione Negata* documented the impossibility to improve the psychiatric institution. Any attempt, including the therapeutic community, was rejected as a re-production of the authoritarian system that was at the core of the manicomio. As a consequence, and in line with what illustrated in chapter IV, the report moved from a reflection of the psychiatric practices and setting, into a political dimension:

The destruction of the psychiatric hospital is a political job because the dissolution of the traditional psychiatry has left psychiatrists and patients facing new problems related to the violence of the full society (Jervis, 2014, p.318).

The therapeutic community was accused of recreating a system based on "medical technical power" (Slavich, 2014, p.199) through "the formation of a community superstructure" (Slavich, 2014, p.198). If from one side, this attention to the social dimension outside of the hospital and the rejection of the therapeutic function can be assimilated to the demedicalization of the English discourse through the call of experts from the social science, in the Italian case, we are talking of a completely different strategy. *L'Istituzione Negata* rejected any classification of the individuals because it was acknowledged as "discriminatory" (Basaglia, 2014b, p.36).

While the English reports were an attempt to formalize new techniques for the production of knowledge on the patients and social dynamics, the Italian reports, in particular, the second one, sought to produce a different type of knowledge. Their aims were to create awareness among normal people, rather than validate new techniques as in the English case. The political dimension, the rejection of technologies and scientific language, such as statistics, and the importance of the redistribution of power will be the central elements of the evaluative discourse in Italy, as will be shown also in the next section.

EVALUATIVE STUDIES DURING THE FIRST IMPLEMENTATION PHASE

The national laws that ratified the care in the community of the patients affected by mental illness were followed by the production of numerous evaluative studies. This coincided with an increased interest by social sciences in mental health and illness in relation to the implementation of these policies. While the previous section looked at the reports that promoted the acceptance of alternative practices for the management and care of people affected by mental illness, this section will look at those studies that assessed the implementation of deinstitutionalization itself in England and in Italy.

The documents analysed in this section were all produced during the early stage of the implementation of the national policies. However, chapter V showed that the transformation of the psychiatric services in both countries started before the approval of the deinstitutionalization acts. For this reason, two moments that characterised the English and the Italian studies can be identified (Table 10): the first one saw the creation of the criteria for studying deinstitutionalization, and the second one introduced the proper assessment of the actual implementation. In the English discourse, this coincided with a difference in the object of their assessment: the 1960s was characterised by a stronger focus on the psychiatric hospitals, while the 1970s saw the introduction of studies of community care. The Italian debate, by contrast, was divided into two different moments: an initial phase was characterised by the exchange between experts aiming to evaluate the validity of L. 180/1978, whilst at the second stage regional experiences were collected in order to assess the implementation on the national level.

In line with the differences highlighted in the previous chapters, the English and Italian evaluative discourses differed in many elements such as the roles played by those studies, the types of outcome assessed, and the methodologies applied. The next two subsections will look at the formation of the two national evaluative discourses, stressing these differences in the problematizations of the policy implementations.

Table 10- English and Italian evaluative studies first implementation

English Evaluative Studies First implementation policies	HOSPITAL STUDIES: 1) Predictions: Tooth and Brooke (1961) 2) Assessments: Jones (1962)
	COMMUNITY SERVICES Wing and Hailey (1972)
Italian Evaluative Studies First implementation policies	EXCHANGE STUDIES: Psichiatria e Buon Governo in Fogli di informazione (1979)
	NATIONAL EVALUATIONS: CENSIS (1983) Crepet and De Salvia (1982)

Needs, Beds and Community Care: from efficacy to efficiency

At the beginning of the twentieth century, experts' voices were playing an ever greater role in the English government publications. This was illustrated in chapters IV and V with reference to the Army report and the Royal Commissions. It

was mentioned once more in the previous section: the first report on the therapeutic community was funded by the English minister of work. If, on one side, official documents were the way in which experts validated the efficacy of their methods, on the other side, expert knowledge was used by the English government to provide evidence of problems and justify its strategies. In other words, there was a reciprocal relation between the validation of knowledge and the acceptance of political strategies.

In the 1950s-1960s, a further rupture occurred in this relationship between knowledge and the English government. Experts' voices were no longer only support of political decisions but became those who defined the political strategy. The hospital plan of 1962 was a direct example of this transformation. In 1953, in fact, NHS expenditure became the central object in the English political debate, and experts were called upon to rationalise political decisions in relation to cost calculation, as stated in this quote:

> No nation can hope to have anything like a first-rate modern medical service without spending a great deal of money. Unfortunately, the original estimates for the National Health Service were too low…Alarmed lest this expenditure should get out of control, the Government…appointed the Guillebaud Committee (Anonymous, 1956, p.237).

In order to address the request of the government, the experts of the Guillebaud committee considered if it was possible to "sav[e] money on the one hand and to obtain[n] better value for money on the other" (Anonymous, 1954, p.179), and they tried to achieve "the most effective control and efficient use of such…funds" (Guilebaud report, 1956, p.1) The concept of efficiency became the solution of the problematization of the excessive cost of the NHS, and a central element in the formation of the English evaluative discourse. The underpinning assumption of this concept was that "control [over the costs] may be exercised with more knowledge", so that "funds may be better allocated and better used" (Anonymous, 1956, p.238). The Guillebaud Committee's analysis estimated that the effective costs of health had not been soaring since the birth of NHS; rather, if looked at in relation to the

increase of the population, they had stayed stable. The committee stressed the role played by the hospital management in the containment of unnecessary expenditure and recommended that:

> Having regard to the advanced degree of obsolescence of many hospitals in this country…we are of opinion that £30 million annually would be a desirable rate of capital expenditure for the National Health Service at which to aim over the seven years succeeding the year 1957-58 (Guillebaud, 1956, p.117).

A Hospital Plan for England and Wales (1962) was the product of the indications given by the Guillebaud committee. As is noticeable, knowledge was not just used as a support for political decisions, but experts decided on the strategy itself, even in the distribution of these funds. In the specific case of psychiatric hospitals, the "statistical inquiry"[49] (Minister of health, 1962, p.5) produced by a statistician and a medical officer, namely Brooke and Tooth, gave the indication of the reduction in the provision of psychiatric beds on the basis of a prediction of the future needs of the population. The experts predicted a strong reduction in psychiatric bed needs in the coming years on the basis of past hospitalization trends, death rates, the availability of new "physical treatments" (Tooth and Brooke, 1961, p.710), and community care. Although the opinions on the conclusion of this analysis diverged among the experts in the field[50], this predictive study impacted on the deinstitutionalization discourse in various ways. First of all, it supported the strategy of reduction of hospital beds and promoted the effectiveness of drugs and community care for the treatment of mental illness. Moreover, it marked the beginning of a process of technologization of the English discourse on the services for people affected by mental illness that was central to the formation of the evaluation discourse.

In the 1960s, in fact, it was possible to notice an explosion in the production of studies concerning the construction of criteria to evaluate mental health services.

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[49] It was referring to Tooth, G. &, Brooke, E. (1961). Trends in the mental hospital population and their effect on future planning. *Lancet.*

[50] See the debate included in The Lancet under the headline "Needs and Beds" started in 1961 with Tooth and Brooke's analysis.

The quantification of "needs" (Minister of Health, 1962, p.3) was largely problematized by the experts:

> Firstly, no-one has succeeded in laying down satisfactory criteria, by which an independent observer can recognise and testing 'clinical need'…Secondly, no worker in this field has yet taken adequate steps to eliminate observational bias…Finally, although most of the cases in a medical ward are acute admissions, assessments of 'clinical need' appear, in general, to have been made retrospectively. It is only too easy to be wise after the event and miss what has been an urgent clinical situation demanding admission. It may well be that there are no practical means of meeting these criticisms of method; but until they are met, figures based upon estimated 'clinical need' will, I submit, merit little confidence, at least in a scientific sense (Norton and Waind, 1961, p.884).

"Needs and resources" (p.107) were acknowledged as essential variables for outlining "indices of efficiency" and for avoiding the distinction between "good hospital and bad hospital…made on a very superficial basis" (Jones and Sidebotham, 1962, p.3). As for the reports described in the previous section, these evaluations of mental hospitals and outpatient services (Jones and Sidebotham, 1962; Farndale, 1961; Hoenig and Hamilton, 1969; Brown and Wing, 1970) were promoted and funded directly by the Department of Health. I stress this element as it was an important feature of the relation between knowledge and political strategy in the English context. Another common element between the two types of analysis was the use of quantifiable variables. Hospitals and other facilities (e.g. day hospital) became the objects of detailed measurements, such as "proportion of 'cures' or recoveries", "admission rate", "medical clinical time", and "average cost" (Jones and Sidebotham, 1962, p.123), or "range of treatments" (p.15), "frequency of attendance" (p.18), "size" (p.19), and "location" (Farndale, 1961, p.20), but there were two differences to emphasise. First of all, in the reports described in the previous section, social dimensions and patient information were collected and quantified to illustrate the effect of the method on the individuals. Thus, the main

aim of the assessment was the therapeutic validity of that specific practice. These studies, by contrast, quantified the social variables in terms of costs and expenditure in order to assess the efficiency of the services. Secondly, reports produced before the law focused on singular experiments, while these studies were trying to assess national and regional services.

Studies on the hospitals were extended on the national level. In 1962, Jones and Sidebotham pointed out that "in recent years, statistics have shown a considerable change in the role of the mental hospital within the Mental Health Service" (1962, p.1). In the attempt to standardise and take under control any procedure in the hospital, such as the "judgement concerning need for admission" (Wing and Hailey, 1972, p.206), it became a place where information about specific populations could be collected. New criteria of evaluation were introduced such as the reasons for admissions in relation to the patient, the professional, but also the role of the relatives in the procedures of admission. All the analyses were characterised by a shared focus on the social variables, with the aim to build a standardised method executable on the national level by trained staff. The main differences between the reports illustrated in the previous section and these studies were the attention paid to *costs* and the aim to increase the efficiency of the procedures applied. As seen in the previous chapter, records in the mental hospitals were not something new, and commissions and boards of control have always had the function of controlling professionals and procedures of admission in order to safeguard the liberty of individuals and their properties. However, this new call for external experts from the social sciences, with the function of evaluating the efficiency of the services on the regional and national level, was something different. These studies were aiming to trace trends of admissions, recovery, and discharge in relation to regions and groups of patients. The attention was not focused on the individual or singular services, but on a larger portion of the population, which was categorised on the basis of their specific needs. In this sense, diagnosis became a further element of evaluation and categorisation, as the evaluative studies aimed to identify the specific features of services dealing with a definite type of patients. People affected by schizophrenia were one of the main groups under analysis; they were

considered the patients who mainly needed the use of hospitals (Wing and Brown, 1970). This consideration of the whole population was in line with the strategy highlighted in chapter V in relation to the birth of the NHS.

In the attempt to analyse services, statistics impacted on the formation of new psychiatric procedures and practices. The English evaluative discourse was characterised by the attempt to apply a scientific method in the control of cost and needs, which was very similar to the control of social variables highlighted in the previous section. However, while previous medical studies were mainly based on the direct experiences of professionals, now these studies were supported by the use of statistics "to provide a new service in keeping with present needs" (Baker, 1961, p.656).

The prediction made by Tooth and Brooke did not impact only on the reduction of the hospital beds, but it also had a productive effect on the development and extension of community care. On the basis of this prediction, the Hospital plan of 1962 stated that the bed reduction was possible only in relation to "the expansion of community mental health services" and "advances in medical treatment" (Ministry of Health, 1962, p.5). The political strategy of the 1960s was characterised by the belief in the potential of community care to be more efficient than hospitals both in cost, and the satisfaction of patients' needs. This attention on community care was also supported by the increased attention from the evaluative studies. In 1972, the Nuffield Provincial Hospital Trust published one of the first studies on community care, aiming to create "intensive studies" as opposed to predictive ones, which were ironically defined as "guesswork" (Wing and Hailey, 1972, p.8). Thus, the birth of the evaluative discourse in England was contemporaneous with the formation of the deinstitutionalization discourse. To a certain extent, it sped up the process of its implementation, accelerating the reduction of psychiatric beds and pushing the creation of community service, in the name of efficiency.

Community services and fragmentation

A few months after L. 180/1978, the Italian government approved L. 833/1978 *on the Sistema Nazionale Italiano* (SSN- *National Health System*), which encompassed

the former law, leaving the Italian system without a special regulation for the care of mental illness (see chapter V). Although L. 180/1978 and L. 833/197 were national reforms, their implementation was left to the Regioni (see the previous chapter) which implemented them with different paths and approaches. This variety in the implementation of the reform was also reflected in the Italian evaluative discourse that emerged from the debate between those who supported L. 180/1978 and those who were extremely critical against the law. While evaluative studies in England were focused on identifying the most efficient practices, Italian evaluative studies aimed to assess L. 180/1978. In the few years after the approval of L. 180/1978, the reform was accused of being unsatisfactory:

> A reform of this kind was bound to be a failure, because of the high dose of populistic optimism that required people to believe that in the absence of adequate inpatient and outpatient services or specialized personnel, an adequate mental health organization could be set up (Sarteschi et al., 1985, p.36).

The law was accused of being incomplete and inefficient. It was argued that the reform "disoriented physicians and psychiatrists" (Sarteschi et al., 1985, p.36) causing disruption in the psychiatric care and "fall in psychiatric standards" (Sarteschi et al., 1985, p.37) were reported in relation to the rejection of using traditional diagnostic approach to mental illness. Moreover, it was reported an increase in the number of admissions of psychiatric patients in private hospitals (Sarteschi et al., 1985).

As seen in the previous chapters, L. 180/1978 and Psichiatria Democratica arose in a very unique and controversial political historical moment in Italy. As explained by an English observer:

> Many of Italy's public services [were] in a state of chaos. With about 1.600.000 men unemployed, more than a million of whom are under 30...problems [were] acute. In 1977 about 2000 bombings took place in Italy and there [was] almost a begrudging acceptance of degree of violence...The

demise of the Christian Democratic Party, after 33 years of control, has resulted in greater instability (Hanvey, 1978, p.22).

This political background was used by those who did not agree with the psychiatric reform to attack the law itself. Sarteschi et al. (1985, p.33) pointed out that:

Ideological pressures in the late sixties and seventies, the objective and urgent need for a soundly based approach to the problem, and indecisiveness and clashes in parliament and in political parties, came together to bring issue of a change in the law on psychiatric care to a stalemate overcharged with tension. In this situation, the Italian Radical party called for a referendum to abolish mental hospital through the abrogation of the 1904 Act. To forestall this, the main political parties were forced to come to an agreement

The political origins of L. 180 were used as a justification for "the lack of any adequate plan to set up all necessary outpatient services, together with the absence of any provision in the law for their funding" (Sarteschi et al., 1985, p.39). Italian commentators pointed out that the need of the Parliament to find an agreement in a very short term led to the approval of an unsatisfactory project that "has produced an absolutely chaotic situation at the local level" (Sarteschi et al., 1985, p.39). In particular, it was stressed that in the rush of approving L. 180, the government did not consider the different level of implementation of services in the community on the national level (Paparo and Bacigalupi, 1982). Critiques against the law stressed that "local psychiatric services [did] not…cover the whole country" (Sarteschi et al., 1985, p.39). As explained by Canosa (1979, p. 187),

While the elimination of the manicomio was immediately implemented in those places where this process was already started (e.g. Trieste, Arezzo, Perugia, Reggio Emilia, Parma, etc.), other places, in particular, bigger cities, mainly in the South, experienced many difficulties.

The regionalization of the health system resulted in a high level of fragmentation among the Italian regions, in particular between the North and the South and in the way in which the reform was implemented, or not implemented. For instance,

Paparo and Bacigalupi (1982) illustrated the differences between the North and the South in the voluntary and involuntary admissions linking them with the accessibility to community-based services:

> Such a severe shortage of psychiatric staff and alternative resources available in the community in the South, associated in the same South…with a marked reduction in compulsory admissions not paralleled by an increase in voluntary admissions, is – in our opinion- rather alarming (p.439).

This fragmentation and lack of central control in the national enactment of L. 180/1978 was problematized during a conference attended by professionals and politicians working in the psychiatric sector and aiming "to verify the state-of-art in the implementation of Legge 180 after 8 months" (Agostinelli, 1979, p.388). The resulting report, *Psichiatria e Buon Governo,* was an attempt to supervise the actual regional implementation of the law, but also a counter-manoeuvre to "the alarmism spread in order to invalidate Legge 180"[51] (Anonymous, 1979, p.412), as explained in this quote:

> It is necessary to stress that in the case when forces against the reform would try to delay or transform the essence of this transformation…they will face all the levels of governance that respect and implement the law (Agostinelli, 1979, p.388).

The report was based on the collection of various psychiatric experiences, aiming to underscore the soundness of the law, but also to point out problems and causes of "delays" and "resistance" (Agostinelli, 1979, p.388) faced during this first part of the implementation. The function of this evidence was to outline recommendations to improve the actual state of the law, to highlight the risks of a possible bad implementation, but, most of all, to reinforce its credibility:

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[51] The Minister of Health in 1979 was one politician of the Liberal Party, which was the only one to vote against Legge 180. From 1979 to 1983 saw the creation of seven proposals for a new psychiatric law, no one of them was approved.

The issues related to the implementation of the reform are not due to the law, but to its interpretations that, even if they look apparently correct, they are likely to the reproduction of the institutional needs, rather than overcoming that model (Casagrande et al., 1982, p.171).

The Italian reports were characterised by very few quantitative data, such as the number of discharges and admissions, TSO rates, and the number of services active in the community[52]. They intended to offer a general frame, rather than measure the reform itself. As for the Italian reports on the therapeutic community, the main objects of the statement were the experiences of the people working in the implementations (politicians, psychiatrists and psychologists). However, in this case, patients and relatives were excluded by the debate. The disappearance of this element, which was central in the reports described in the previous Italian section, is noteworthy, as it denoted an important rupture from the previous discourse. This assessment, in fact, was targeting a public different from that targeted by the previous reports. It aimed to increase the credibility of the reform among the professionals working in the psychiatric services, but also among the politicians, who were in charge of funding and promoting the deinstitutionalization policies on the regional level.

Rather than assessing what had been done, the report was seeking to point out what needed to be implemented, and how. In this sense, the exchange of experiences between the professionals was not limited to the illustration of the best practices, but included an illustration of the bad ones:

There are too many interests that work together in order to maintain the 'status quo'. In some general hospitals, there are head doctors who even ask for one nurse for each patient...with the risk to the reoccurrence of custody (Agostinelli, 1979, p.388).

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[52] These data were collected by the CNR and included in two pages under the headline: First data on the psychiatric services after the approval of L. 180/1978.

As can be seen from this quote, this debate was, to a certain extent, a criticism of those professionals who were sabotaging the implementation of the reform, putting their interests first. This complaint was not limited to the medical level but also referred to the political one, as demonstrated by this passage: "all the government delays must be removed soon; otherwise, the implementation of the health reform will be difficult and problematic" (Agostinelli, 1979, p.389). While the objects of the English analysis were the patients or the efficiency of the services, the Italian evaluative discourse was focused on the authorities involved in the implementation "at all levels" (Agostinelli, 1979, p.388). The assessment did not concern the services, but it was an inquiry regarding the professional and political engagement with the reform itself in the *territory.*

> The territory is an alternative [to the hospital] aimed at the reconstruction of the social power…in the hands of the person released from the manicomio into the city, without forgetting that social power is chiefly an economic power (Rotelli, 1979, p.393).

The territory became a central object in the Italian evaluative discourse. On one hand, life in the territory was opposed to life in the psychiatric hospital. On the other hand, this concept was not used to describe life outside the hospital's walls, because the simple discharge of the patient from the institution was associated to the risk of recreating the same conditions of the hospital, such as division and exclusion, in the city (Rotelli, 1979). In other words, territorialisation was not limited to the movement of the patient from one place to another, but it was related to the construction of a new culture where the patient was not isolated anymore, but an active member of society. The territorialisation of the patients implied the creation of the circumstances that enabled the patients to possess a power that they did not have in the hospital. This power was described in economic terms:

> Nothing as money and the circulation of property break the bounds of unproductive institutions, modify taboo and prejudices, change cultures, and free them from their oldness (Rotelli, 1979, p.394).

One criterion for the assessment of the work made by the professionals in the implementation of the psychiatric reform in Italy concerned the capacity of the psychiatrist to make the patient capable of being part of economic exchange. The psychiatrist, in fact, was defined as a "technician of money" (Rotelli, 1979, p.394). While costs were analysed in the English discourse in relation to the efficiency of the services, in the Italian discourse the economic factor was an element of analysis in relation to the opposition between productivity-unproductivity of the services and the patient in the service. While the psychiatric hospital was defined as "unproductive"[53] (Rotelli, 1979, p.394), the reintroduction of the patients to the territory implied their inclusion in the economic exchange through the possibility of asking for a job, housing, benefits. In this sense, the territorialisation of the patient entailed the integration of the patients in relation to their right to make a request and be an active member of society in economic terms.

This first assessment was an essential condition for the formation of the Italian evaluative discourse, as it introduced the main elements of the Italian evaluative discourse, such as the focus on validating the reform against the hospital and the introduction of the concept of territory. Most of all, it enabled the problematization of "the lack of a documentation…able to describe…the actual state of implementation of the national public psychiatry (Ciotti, 1982, pp.7-8). At the beginning of the 1980s, various studies were published with the aim of giving a better understanding of the implementation of the law on the entire national territory. These studies were "series of documents" (De Salvia and Crepet, 1982, p.15) from different parts of Italy that were "not commissioned", but "collected by the editor" (De Salvia and Crepet, 1982, p.15), and published by various research institutes, such as Psichiatria Democratica, CNR, Censis-Ciseff and so on. While in England, experts were directly involved by the government in order to plan future strategies, the Italian studies were not directly requested by the government. The Italian studies were a reaction to the "alarmism" (Anonymous, 1979, p.412) described at the beginning of this subsection. They aimed to increase the credibility

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[53] In chapter VI, the psychiatric patients were described as a proletariat stripped of his only strength, which was his productive capacity.

of L. 180/1978 against the rumours saying that the law was abandoning patients without services evaluations, and, as such, they were not focused on the "efficiency" of the policies, or of the services, but on their "efficacy" (Ciotti, 1982, p.2). In this sense, they were characterised by a different style from the English ones. The number of beds, admissions and discharge were used, as in the English discourse, in order to prove the success of the reform, but they were not the central object of the discourse, because the "fast reduction of beds" (Ciotti, 1982, p.2) was problematized as a form of neglecting patients, rather than as an absolute criterion for the success of the reform. One of the main complaints against L. 180/1978, in fact, concerned the "uncontrolled discharges" (orig. dimissioni selvagge, Scarpa, 1981, p.51) of patients who were left without a place to go. The numbers of beds and admissions, by contrast, were used as "the descriptive element for an analysis that [was] mainly qualitative" (Ciotti, 1982, p.2). In other words, the attention of the evaluation was focussed on the processes, rather than on the outcomes, of the reform and practices. As explained in the quote below:

> The assessment…involves the analysis of the ways in which the psychiatric practices overcome the traditional institutional psychiatry, and the analysis of the problems raised by the transformation of the psychiatric intervention in the territory[54], in relation to the new issues that have been submitted to the services (De Salvia and Crepet, 1982, p.15).

The main aim of the reform, and, consequently, of the investigation, rested in the elimination of the psychiatric hospital as a setting for psychiatric practices. Moreover, the process of territorialisation implied the introduction of the capacity of the psychiatric services to address the variety of local needs as further criteria of evaluation. As seen, the English evaluative discourse problematized hospitals in terms of cost and quantified the number of beds needed: the rationale was not the complete elimination of the institution, but to improve the efficiency of the whole system. The Italian evaluative discourse, by contrast, kept the focus on the

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[54] Castel et al. (1982) in Psychiatric Society has translated the Italian "territory" with community, but I have decided to use the literal translation, explaining the meaning of this word in the Italian discourse.

complete deinstitutionalization of the psychiatric services. In this sense, the evaluative discourse reflected the different rationales on the basis of the two national deinstitutionalization discourses: while the Italian discourse had as the main goal the complete abolishment of institutions, the English one was considering how to integrate them into the system in the most efficient manner.

This difference was also illustrated by the shared but different use of the concept of *needs* in the two national discourses. *Needs* were still a central object of the Italian discourse, but not as objects of quantification and measurement. Evaluative studies were focused on understanding how, and if, the new psychiatric practices were able to address them. Needs had a strict connection with rehabilitation and territory. According to the Italian discourse, "rehabilitation ha[d] different rates and it is not possible to think to gain everything at once" (Ciotti, 1982, p.2), and these different paths did not concern only the patient, as an individual, but also the context where he or she was included. The reintroduction of the patient into the community was related to the creation of new needs in the community, and the psychiatrist with the politicians played the function of satisfying them. "*Territorialisation*" took on a broader meaning, which was not limited to the economic dimension. Rather, it implied the relationship between the territory and its needs, as the territory was the place where the needs were, and each community was characterised by specific needs. The evaluative discourse reflected this rationale, rejecting any form of standardised and generalised assessment. Talking about the Italian studies on deinstitutionalization, Ciotti (1982) explained that each assessments "describ[ed] specific communities" (p.7) and, as such, it was impossible to "generalise [them] as representative of the whole national condition" (p.7) in the psychiatric care.

The reports were a collection of regional psychiatric experiences, as their aim was to grasp and provide a description of all the differences between the implementations around Italy. Moreover, great attention was paid to "avoid[ing] the separation between the moment of the research and the care practice" (De Salvia and Crepet, 1982, p.15). Although this style was very similar to the one applied by the Gorizia reports, it differed, as these individual stories were collected

by external editors, who gave them new interpretations, and new credibility, to them. The general reform itself became the object of the discourse not just in terms of self-reflection (see chapter IV), but a historical dimension was added by the external analysts. However, the style applied by these editors was not scientific: they were not statisticians, as in the English inquiry, but political groups, or even institutions funded by the church, like in the case of the Censis-Ciseff report.

This feature was also stressed by the lack of use of diagnostic categories and epidemiological statistics. Although data on patients and services were separated on the basis of the type of admission and geographic area, medical categories were not used. The lack of statistical data about the patient was recognised as a deliberate specific practice:

> The epidemiological tools, as they are usually applied in psychiatry, are highly corrupted by the attempt to catalogue/census/record (Censire) the illness. This approach is strongly rejected by the attempt to depsychiatrize the procedures that underpin the analysis of this type of evaluation (De Salvia and Crepet, 1982, p.15).

Thus, the formation of the Italian evaluative discourse originated in the necessity to safeguard L. 180/1978 against those critiques that were seeking to challenge its validity. Their aim was to continue the process of deinstitutionalization and to avoid new forms of institutionalization and divisions of patients in the community. Tools such as epidemiological statistics were also rejected; they were considered as further dividing practices. The assessments were promoting the participation of any level of governance, from politicians to religious groups, in the implementation of the law. As this passage makes explicit: "each of us must make a commitment on his own behalf in order to make the law work" (Ciotti, 1983, pp.3-4).

THE INTERNATIONAL DEBATE: THE NEED FOR A COMMON LANGUAGE

The previous sections illustrated the close relationship between the formation of the national evaluative discourses and the acceptance of, and the way towards implementing, deinstitutionalization policies in Italy and in England. As seen, each

country was characterised by very specific ways of assessing these national policies that were tied to the specific problematizations and rationales related to the national context. The English discourse, for instance, aimed to assess the services in terms of efficiency. Most of these studies were directly funded by governmental organizations to lead, support and validate political strategies on the national level. For this reason, experts were seeking to outline standardised criteria to measure and compare the results of services to offer guidelines to be followed all around England. Italian evaluative studies, by contrast, were mainly a collection of experiences from the different regions. The aim of these reports was to outline the national implementation of L. 180/1978, but not to look for the most efficient service. Rather, the aim was to enable the exchange between experts and politicians. The complete abolishment of institutions and any forms of exclusion and division of the patients was favoured. Moreover, Italian studies were characterised by the complete absence of any standardised data on the national level, as the assumption was that each territory was characterised by very specific needs, and as such comparisons on the national level were considered not relevant.

Although previous chapters have illustrated the national specificity of the formation of the deinstitutionalization discourses in England and in Italy, it is important to notice that an international dimension has always existed. In the English Army report, and in the paper on social psychiatry, there were continual references to the use of psychological selection in the American Army, or to the American Mental Hygiene Movement, and the WHO had been promoting the implementation of mental health services in the community since the 1950s. Chapter IV showed also the close relationship between the Italian Gorizia experiment and the English therapeutic community, and the reciprocal attention between Laing, Cooper and Basaglia. However, these considerations were internal to the Italian and English debates. International experiences were used as a reference, or source of reflection and critique, but they never became the object of international debate. Rather the discourses on the national experiences followed the national rules of formation in relation to the specific conditions investigated in chapter IV and V.

The 1980s marked an important rupture in the national discourses in relation to the acknowledgement of deinstitutionalization as an international trend. As seen also in chapter II, deinstitutionalization became the object of various investigations on the international level. These aimed to compare and evaluate the level of achievement of this goal in different countries. In particular, in 1985 a full special issue, namely *The Unfinished Revolution in Italian Psychiatry: an International Perspective*, was dedicated to the international debate on "the Italian Experience" (Basaglia, 1980; Jones and Poletti, 1985). The Trieste[55] experience was defined by the WHO as "the most comprehensive community-oriented mental health act in the Western industrialized world" (Mosher, 1982, p. 199). This rupture allowed the multiplication of discourses and debates concerning the Italian reform on the international level. For the purpose of this research, though, the following section will focus on the inclusion of the Italian experience as an object of the English discourse, and the impact of this international dimension on the Italian one.

> In 1984, MIND sponsored exhibitions and discussions in London, Manchester and Sheffield in which supporters of the Italian movement, Psichiatria Democratica, described its successes (Jones and Poletti, 1985, p.341).

"British enthusiasm for Psichiatria Democratica" (Cigno, 1985, p.173) enabled the problematization of the English deinstitutionalization in relation to the Italian reform: "clearly, there are lessons for Britain in the Italian Experience" (Heptinstall, 1984 in Jones and Poletti, 1985, p.341). However, positive interpretations were mixed with negative accounts. In any case, the focus of this subsection is not on the outcomes of these studies, but on how the English discourse assessed the Italian experience. English experts, in fact, started to visit and investigate psychiatric services in Italy with the aim to understand and to check if this could help to improve the implementation of deinstitutionalization in England.

The Italian reform was an actual example of the possibility to completely abolish the psychiatric hospitals, and attention in England was focused on the feasibility of

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[55] Trieste was the last psychiatric hospital experiment made by the Basaglia and the first Italian hospital to completely discharge all its patients, even before the approval of L. 180/1978 (Foot, 2014a).

this. On the basis of this aim, all the main features of the Italian experience illustrated in the previous chapters, such as the rejection of statistics, the depsychiatrization, and the politicization of the psychiatric discourse, were problematized by the English discourse:

> When the interpretations of a new development in policy are so hotly disputed, it seems advisable to look for statistical evidence. Unfortunately, up-to-date statistics are both patchy and uninformative (Jones and Poletti, 1985, p.197).

> The decision that somebody was mentally ill was essentially a political decision. Those who worked were defined as "sane" and, those who could not work were defined as "sick" and dangerous to community life. The "sick" were handed over to the doctor, to be isolated from society" (Jones and Poletti, 1985, p.342).

Not only was the Italian reform assessed in relation to its implementation, but "the writings of Franco Basaglia [were] critically reviewed, both from a technical psychiatric point of view and from a general political and social one" (Papeschi, 1985, p.247). In other words, the entire Italian psychiatric discourse and its practices became the objects of a process of assessment and validation according to criteria that were not those of the Italian discourse, but those ones of the English psychiatric and evaluative discourse discussed in the previous sections. It is important to stress that this problematization of the Italian discourse and practices was not made only by those who were critical of this approach, but also by the English experts who supported it. As an English expert wrote about Trieste's experience:

> It is difficult to attempt an evaluation of the regional psychiatric service in Trieste. Information was not available that would enable one to assess to what extent the service was preventing or lessening morbidity, distress, and disability for the patients and for those with whom they were living. In the absence of such information…I [Bennett] summarized my observations under headings suggested by Wing (Bennett, 1985, p.87).

What is relevant for my analysis is not the criticism by the English experts of the Italian reform, but the way in which the English discourse applied its rationales and specific rules of the discourse on deinstitutionalization to the Italian context. The English experts were looking for statistics, types of expertise, standardised criteria to assess if the Italian experience was more effective and efficient than the English one, imposing their evaluative criteria on the Italian reform, and without considering the Italian context, as explained by one of the English experts:

> Referring to Jones and Poletti's article on the Italian psychiatric reform…I would like to point out [that]…the authors seem to be somewhat out of touch with the Italian social context… This is exemplified in omitting to mention the impact of 1968 on the whole of Italian society (Ramon, 1985, p.208).

Although these acknowledgements of the limits of the English studies on the Italian experience, the latter was invalidated because of the lack of reliable data and scientific theory to support the feasibility of psychiatric care services without hospitals.

> The 'Italian experience' [has been] used as a lever for change, with the implication that mental hospitals can be abolished without extensive and expensive substitutes, that patients can be reabsorbed into the community without pain or effort. The real lesson is that this has been tried in Italy, and has failed (Jones and Poletti, 1985, p.347).

Thus, any attempt to challenge the English system, and the proposal of a complete closure of the psychiatric hospital, was rejected in the English context. On the other side, the International debate worked as an agent of transformation on the Italian discourse, imposing to a certain extent the use of statistics and attempts to include data related to cost in the evaluation of the services. As seen in the previous section, L. 180/1978 was under attack by those who rejected its implementation, and the international debate gave space to those Italian voices that were critical of the reform. The following are some of the Italian psychiatrists' assertions published by foreigner journals:

This law 'forgot' such patients, as well as adversely affecting the treatment of acute patients, for whom an insufficient number of psychiatric beds was permitted in general hospitals (Papeschi, 1985, p.247).

Both care-givers and patients suffered disorientation as a result of the changes the law brought; disruption of the system occurred suddenly, before new services could be organized. Even now there is no program for reintegration of patients into the community, which was one of the basic intents of the new law (Cassano et al., 1985, p.175).

In correlation to the formation of this international discourse, the lack of quantitative data was problematized also by the Italian discourse itself:

The 'Italian experience' of providing psychiatric care with comprehensive and integrated community services while blocking admissions to mental hospitals needs evaluation on the basis of quantitative evidence as well as opinion. In this paper, national statistics and local case-register data pertaining to this issue are reported (Tansella et al., 1987, p.37).

A new approach to the evaluation of the reform was applied in order to illustrate the effectiveness of the Italian services in the community. Standardised scales were introduced to evaluate the impact of the services on patients, as in this study on the community mental health service of Verona: "the assessment instruments used were the WAS and the COPES, two true/false self-rating questionnaires developed by Rudolf H. Moos and associates" (Burti et al., 1990, p.196), and in 1992, a national journal of epidemiology and social psychiatry was published. As explained by the editor of the first publication,

It is necessary to explain what has been the main reason that has led to the foundation of this journal, namely the growing awareness in our country of the psychiatric epidemiology…The importance of this discipline, or approach, which has old and strong tradition in other countries, is, for us, a novelty that is rapidly developing in the last year also in Italy (Tansella, 1992, p.1).

The Italian discourse changed in relation to the international evaluative discourse in the attempt to stress the "scientific significance" of the experience of Gorizia as this "has not been sufficiently discussed and evaluated" (Crepet and Pirella, 1985, p. 160). Basaglia's work was framed as a psychiatric theory, stressing the academic background of the author, who was described as "the herald of the institutional epistemological crisis in traditional psychiatry" (Crepet and Pirella, 1985, p.155). Although the attempt of showing how the Italian discourse was different from the other psychiatric approaches, which led to deinstitutionalization in the other countries, and how the Italian experience was unique because of its "political, cultural and scientific climate" (Crepet and Pirella, 1985, p.157), the Italian discourse was explained in terms of a new theoretical approach to psychiatry, rather than in terms of the end of psychiatry, as seen in the previous chapters. This transformation was also stressed by the fact that, while previous assessments were edited by other people from different backgrounds, these new studies were all produced by psychiatrists – not just psychiatrists working in psychiatric services, but also academics from a medical background.

It is important to notice that this imposition was not the result of violence or force but was related to the production of "truth discourses". In other words, the supranational dimension impacted on the formation and acceptance of new rules in the Italian discourse, and also at the introduction of practices aimed to the creation of other forms of knowledge, such as the epidemiological analysis. In order to validate its discourse on the international level, the Italian discourse had to apply the rules applied by the English discourse to increase the credibility of its reform. The Italian evaluative discourse changed to make its discourse intelligible to the international discourse (Anglo-Saxon discourse).

Conclusion

This chapter illustrated the formation of the national evaluative discourses on deinstitutionalization in Italy and in England. The focus of the analysis was not on their outcomes, but rather on the positive function that these studies had for the deinstitutionalization discourses and their related practices. In this sense, this

chapter differed from previous studies on deinstitutionalization, such as Jones's (1993) work or traditional cross-national evaluative studies. The chapter showed that although evaluative studies aimed for external assessment of the practices, they were completely involved in them and, as such, worked as productive stances in the validation, transformation, or rejection of elements of the discourse. The Italian and English reports on the therapeutic community methods, for instance, enabled the acceptance of specific national problematizations of the psychiatric hospitals and practices, and the inclusion of new objects, such as the quantification of social variables in the English psychiatric discourse or the political dimension in the Italian psychiatric discourse. In this sense, their analysis is valuable as they can provide a further angle on the formation of the national discourses. The chapter has mainly corroborated the previous results. The rationales at the basis of these assessments confirmed the relationship in the English discourse between the centralization of power, efficiency and the problematization of the psychiatric hospital and the creation of community care. In the case of the Italian discourse, the evaluative discourse was the result of the continuous struggle among different levels of power. However, the analysis of the formation and transformation of the evaluative discourse also made it possible to take into consideration an unexpected dimension: the international dimension. The last section, in fact, illustrated the impact of the inclusion of deinstitutionalization as an international trend in the validation of the English deinstitutionalization discourse and the Italian one. This finding is distinct from the substance of previous studies on deinstitutionalization in that they always analysed this transformation as an international trend. The similarities and differences of the findings of this chapter and the preceding chapters with previous studies on deinstitutionalization will be discussed in more detail in the next chapter.

CHAPTER VII: DISCUSSION

Introduction

As seen, until the middle of the last century, mental illness was treated in long-stay institutions. But transformations in psychiatric theories and practices as well as in the social and political modes of relating to psychiatric patients and mental illness led to the movement of psychiatric care in the community. This shift has been named deinstitutionalization (Bacharach, 1976), and it has been the subject of heterogeneous studies. Chapter II divided these inquiries into four main approaches: "Deinstitutionalization as a goal"; "What has been learned from the past?"; "Decarceration and social control"; and "Governmentality studies". Studies that have looked at deinstitutionalization as a goal seek to outline indexes for evaluating the efficacy and effectiveness of deinstitutionalization policies and their implementations on the national and international level. The results of these studies are quite contradictory regarding the rate of success or failure of deinstitutionalization policies, but they agree on the high level of fragmentation among European countries. However, this approach has been unable to illustrate the reasons for these variations (Shorter, 2007), as it has focused only on the present state rather than seeking to comprehend the processes that led to deinstitutionalization. The other three approaches, by contrast, applied various social theories for the historical investigation of this transformation. Despite the attempt to outline a comprehensive model for explaining deinstitutionalization, chapter II agreed with other reviews on deinstitutionalization studies that "all these appraisals tend to illuminate only some aspects of the process while obscuring others" (Novella, 2008, p.303). In particular, the literature review stressed that previous studies, except for a few cases, such as Goodwin's work (1997), have underestimated the importance of national differences in the implementation of deinstitutionalization. Even governmentality studies, which investigate the formation of specific practices and discourses in relation to particular modalities of government, have not considered their international heterogeneity, but have tended to generalise a local analysis to all western countries (Rose and Miller, 1988). The present study has aimed to make up for this general lack of attention to

international differences. Specifically, the main objective of this study has been to expand the comprehension of the differences between mental health care systems in different European countries, looking at the birth of the deinstitutionalization policies.

Chapter II argued that at the core of this gap in knowledge of international differences in deinstitutionalization has been the assumption – shared by studies following the aforementioned approaches – that this shift was a univocal process which involved all western countries. The present study has challenged this assumption, showing that the formation of discourses and practices was strictly related to national historical, political, economic, and social contexts, and that, as such, it is essential to study them in relation to their specific conditions. In order to achieve this aim, this study has applied a cross-national archaeology of the deinstitutionalization discourses in England and in Italy. As discussed in chapter III, this method was selected because it enabled the investigation of the relations between multiple discourses instead of a search for common trends or the construction of general theory. The main features of Foucault's tools are: attention to history, in terms of contingencies and ruptures; and an exploration of the local as "the place where objects are defined, subject positions negotiated and strategies are exercised" (Nicholls, 2009, p.36). The application of a cross-national design further stressed these characteristics of Foucault's method, allowing for an emphasis on international differences in the formation of the deinstitutionalization discourses.

While the preceding chapters have reported the presentation and analysis of data collected during this cross-national archaeology of the Italian and English deinstitutionalization discourses, this chapter will provide a discussion of these findings in relation to the existing literature on the subject. The research questions will be addressed throughout The first section will illustrate the transformation in the English and Italian psychiatric and legal discourses on mental illness in relation to the formation of the national deinstitutionalization discourses. Moreover, this section will compare the present findings to arguments based on previous studies

on deinstitutionalization. The second section will review the main differences between the English and the Italian discourse that arose from the findings, stressing the potential of applying a genealogical cross-national method. The third section will focus on the existence of psychiatric hospitals as the main difference between the English and the Italian psychiatric system. The chapter will close with some reflections and suggestions for future research.

To what extent and how did the national psychiatric and legal discourses on mental illness in England and Italy change in relation to the shift from care in long-stay hospitals to care in the community?

The analytical chapters showed that the shift of psychiatric care from the hospital to the community was not a clear-cut event or the product of a univocal strategy, but the result of multiple ruptures and different tactics. Although the archaeological method rejects the unity of discourses, I decided to frame my analytical chapters maintaining the psychiatric and legal discourses as unities. As explained in chapter III, this decision was due to the comparative nature of the study. As seen in chapter I and III, the archaeological analysis stresses the discontinuity in the discourses, searching for the multiple relations and ruptures. Maintaining the unity of the legal and psychiatric discourses made possible to illustrate the differences between the English and the Italian cases, while keeping the narration clear. This section seeks to address the first question while illustrating the coexistence and discontinuity of these multiple discourses on the national level during the shift of the psychiatric care from hospital to the community in the two countries. The first subsection will outline the full transformation of the English discourse, the second will focus on the Italian case, and the final section will compare these findings to those of previous studies on deinstitutionalization.
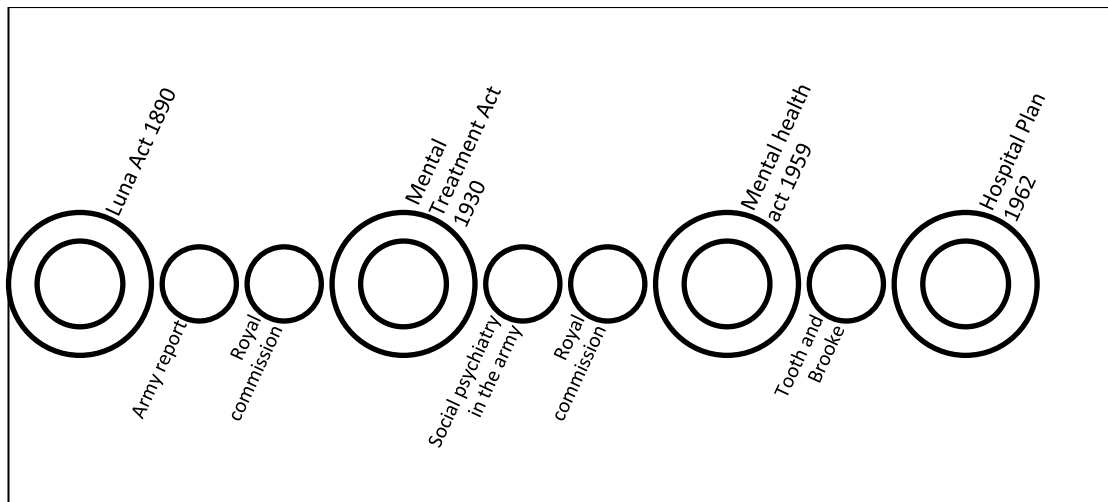
Figure 7- Ruptures in the formation of deinstitutionalization discourse in England

ENGLAND: The formation of the English community care discourse was characterised by three main ruptures, one in the 1920s-1930s, another in the 1940s-1950s, and yet another in the early 1960s (see Fig. 7). These ruptures involved transformations in the psychiatric and in the legal discourses and the acceptance of forms of treatment outside the psychiatric setting, and the approval of new laws, including the Mental Health Act in 1959

As seen in chapter V, *before the first rupture* the English insanity system was almost completely regulated by the Lunacy Act 1890. This law indicated a break from the previous lunatic acts. It ratified a specific system for the national management of lunacy and marked the beginning of a process of centralization of the control of insanity with the introduction of compulsory procedures for the admission of patients to hospitals, namely certification, and with the establishment of at least one asylum for each county. This system dealt only with those subjects who required coercion: patients were supposed to be considered both *of unsound mind* and *with the purpose of committing a crime*. Although this was not the main focus of this study, my findings on the English psychiatric system before the Lunacy Act 1890 were in line with those studies that stressed the coexistence of the asylum with support in the community (Bartlett and Wright, 1999) and the strict relation of the rise of asylums with the Poor Law (Bartlett, 2013). The primary aim of the

psychiatric laws was the exclusion of those subjects considered dangerous because of their mental condition, rather than the cure of mental illness, but people affected by mental illness stayed in the family until they were acknowledged as dangerous. In this sense, I associated the management of insanity with the model used for the isolation of lepers (Foucault, 2005): subjects identified as mentally disturbed and dangerous were stripped of their possession and physically separated from the sane. Once the patients were under the Lunacy Act, they were subjected to another division, similar to the one applied for the control of the plague (Foucault, 1995), characterised by pyramidal and continual form of control. The insane were split, on the basis of class, into three groups and subjected to different procedures of admissions and places of segregation. Doctors were supposed to watch over the patients in the various institutions, to sign the certification for the admission to the hospitals, to keep constant records of each patient admitted, and to control those who were kept in private houses. These institutions, including the staff working in them, were under the further supervision of judges and the control of inspectors and lunacy commissions (chapter V). During this period, the English psychiatric discourse was characterised by a medical approach to mental illness. The diagnosis was based on the observation of the patients' behaviour, and insanity was considered an untreatable and pre-congenital condition (chapter IV) so that coercion was the only form of treatment. If from one angle, this gave scientific justification to the asylum itself, from another, this system validated the existence of a specific medical discipline for the management of the insane in the asylums. Thus the juridical and medical discourses coexisted despite the mainly custodial function of the Lunatic system.

A *first rupture* was identified in the period between WWI and the 1930s. Findings illustrated in chapter IV showed that the increased need of manpower during the war, and the inefficiency of the army disciplinary system in the management of soldiers affected by war neuroses, required the need of new expertise for the control of this epidemic that challenged the army system. This event created the conditions for the externalization of the psychiatric practices outside of the asylums, but it also faced the traditional medical approach for the diagnosis of

mental illness with the acceptance of a psychological approach to mental illness. New concepts were included in the psychiatric discourse such as treatability, social predisposition, and different grades of mental disorders, with a problematization of the clear division between sane and insane, which had been at the core of the previous system. On the basis of this new division, psychiatric hospitals were criticised by the new psychiatric discourse. While asylums were described as the place for dealing with the *end-result* of mental illness, a preventive strategy was proposed as a more efficient way for dealing with those cases that involved dysfunctional conducts than their complete exclusion. These elements of the psychiatric discourse were used in the legal discourse (chapter V) with the approval of the Mental Treatment Act in 1930, which introduced procedures for the voluntary admission and temporary treatment of less severe cases of mental illness, and the institutions of out-patient and domiciliary after-care services. This law eliminated the division based on classes and repealed the Poor Law in the management of mental illness and consolidated the process of centralization started with the Lunacy Act 1890. These elements were all essential conditions for the acceptance of the deinstitutionalization discourse in England as they started a process of normalization of psychiatric intervention outside of the psychiatric hospitals, but it is important to stress that this new English system was characterised by the coexistence of two different strategies represented by the two laws, which were simultaneously active: the Lunacy Act 1980 and the Mental Treatment Act 1930. The former still concerned only those subjects who required coercion because of their dangerousness for public order and it had, as its main institution, the psychiatric hospital. The latter extended the legal discourse to the individuals affected by any form of mental illness without considering their actual dangerousness, with an extension also of the places for the treatment of mental illness.

A *second rupture* was identified in correspondence with WWII when psychiatric knowledge and practices were called upon again by the army to avoid a new epidemic of war neuroses. The psychiatric intervention was not limited to the diagnosis of war neuroses, however. Psychiatrists were involved in different areas

of the military: during the enlistment of soldiers, selecting men on the basis of their psychological characteristics; during the training of officers, training them in both morale-boosting techniques and the reinforcement of *esprit de corps*, and; during the war, in the rehabilitation of soldiers directly at the front-lines (chapter IV). Psychiatric practices were applied on the basis of a strategy of rationalization of manpower, whose aim was to avoiding soldiers being returned from the front for long-term hospital stays, as well as for faster rehabilitation to return to fighting. Group therapy and the therapeutic community were just two of the practices developed during WWII with the function of maximising the effect of psychiatric treatment (see chapter IV). As in the first rupture, the English psychiatric discourse and practices changed in relation to specific needs, in particular, the rationalization of manpower. However, while in the previous rupture the main subject of the psychiatric intervention was still the individual, and the psychiatric hospital remained the main place where psychiatry was practised, this second rupture, by contrast, was characterised by a change in the subject and the place of intervention. Psychiatric practices started to work with groups, rather than individuals, and a multiplication of the fields of application, such as the industry, was noticeable. In line with the political strategies of full employment of the 1940s and the approval of the Disabled Persons (employment) Act 1944, the development of the therapeutic community was linked to the rehabilitation of ex-soldiers affected by war neuroses for their reintroduction into the community. As such it was funded by the Ministry of Work.

The process of centralization of the psychiatric system was completely consolidated with the integration of psychiatry in general medicine and the approval of the National Health Service Act in 1946. Mental health was officially acknowledged as a public problem, and, for this reason, the existence of special laws for the cure of people affected by mental illness was problematized, leading to the approval of the Mental Health Act 1959 (chapter V). This law repealed all previous ones on mental illnesses and completely ratified the centralization of the control of mental health. In line with the principle of the NHS, it provided services for the whole population through the institutionalization of a series of services in the community alternative

to the psychiatric services aimed at the mental health of all English people. However, it was still a special law for mental illness, as dangerousness was still considered an implicit feature of mental illness, which requires the use of compulsory power. Thus, if on one hand, the Mental Health Act 1959 enabled a further extension of psychiatric intervention and institutionalized the creation of services in the community on the national level; on the other hand, it confirmed the necessity of the existence of psychiatric hospitals.

The complete reduction of the psychiatric hospitals was related to *a third rupture* in the English discourse, which was not related to the legal or the psychiatric discourse, but to a change in the function of the experts in the definition of political strategies (see chapter VI). In 1962, a new national hospital plan was approved and, in the case of the psychiatric hospitals, the political strategy was outlined on the basis of a calculation of future needs of beds made by two experts in relation to new treatments and alternative services. This initiated the complete implementation of the policies of deinstitutionalization in England.

ITALY: The Italian transformation of the legal and psychiatric discourses was characterised by two main ruptures, one in the 1960s and one in the 1970s. They were very close to each other (see Fig. 8). While the former marked a strong transformation in the psychiatric discourse, the latter led to the transformation of the legal discourse and the approval of L. 180/1978.
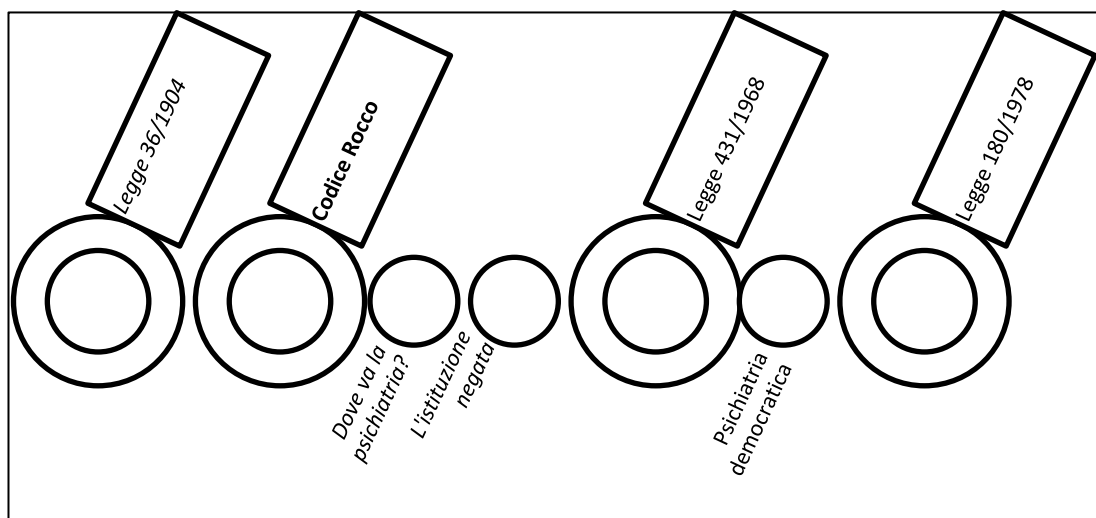

Figure 8- Ruptures in the formation of deinstitutionalization discourse in England

Before the first rupture, the management of alienation was regulated by L. 36/1904 and the penal code approved in 1930 during Italy's fascist era. The former law provided the national frame for the management of the manicomi and the custody and treatment of the alienated, with compulsory admission to psychiatric hospitals of all individuals affected by any form of alienation and considered dangerous for the public order. The latter, by contrast, added some peculiar elements to the previous legal system, such as elimination of any personal and civil right for all individuals admitted to psychiatric hospitals. Moreover, the penal code ratified the inclusion of the psychiatric institutions among the *security measures* extending the compulsory admission to the manicomio for those subjects defined by the law as *socially dangerous* (chapter V). This label had both a medical and a legal status that found its justification in the biological approach to mental illness and criminality of the positivist school (chapter V). In this sense, the Italian representation of the person affected by mental illness resembled in all its main elements the concept of the monster analysed by Foucault (2003): the criminal personality was embodied in the individual, hence no rehabilitation was possible. This medical-juridical discourse was not just a feature of the management of alienation, but a central feature of the full Italian penal system. The penal code, with its *double track system* (sistema binario), was characterised by the coexistence of two completely different strategies for criminality: a punitive and a preventive one. While the former concerned the punishment of those who had committed a crime, who were sentenced applying a very rational calculation, the latter concerned those who had not committed any crime but were considered socially dangerous and segregated into the manicomi. In other words, in line with fascist principles, psychiatric institutions were acknowledged by the Penal Code as "security measures" to safeguard the state against any potentially dangerous individuals, including politically dangerous subjects (see chapter V).

This system remained untouched, despite the fall of fascism, until the 1960s, when the struggle in the manicomio began with the rejection by the professionals of their custodial function (see chapter IV). While the previous system had been based on a strategy of the annihilation of the individuals admitted to the institution through

their isolation from external life and the cancellation of their rights as citizens and persons, the Gorizia experience was a direct attack on this system and on the psychiatric institution as a symbol of it. The *first rupture* was characterised by the complete overthrow of the internal hierarchy of the hospital, the rejection of the medical status of institutional psychiatry, and the problematization of the manicomio as a place of custody, rather than treatment (chapter IV). As seen, in the previous system, the political strategy of annihilation was justified by the formalism that characterised the coexistence of the legal and biological models, and criminals and psychiatric patients were represented as an undifferentiated category of dangerous and unrecoverable individuals. The new psychiatric discourse attacked this system with a strategy defined as "liberation" and worked in two directions: one internal to the institution and another outside of the hospital, in society. The former eliminated any internal hierarchy and division inside the hospital, overthrowing any previous rule (chapter IV) through the application of the therapeutic community method. The latter had as the object of attack the representation of the patients in society. The histories of their lives, the violence they were subjected to in the institutions, and the idea of the patient as a victim of society were used as elements of the discourse for challenging the shared idea of the psychiatric patients as a homogeneous mass of dangerous individuals (chapter IV). This transformation of the psychiatric discourse enabled the problematization of the system that regulated the psychiatric hospitals and a rupture in the legal discourse with the approval of L. 431/1968. However, this law was not a consolidation of the new Italian psychiatric discourse, but rather a counter-manoeuvre of the Italian government to stabilise the protest started in the Gorizia hospital (see chapter V). The legal discourse was used as a strategy to minimise the impact of the struggle started by the Gorizia hospital in 1961 and extended, in the following years, to other manicomi around Italy. L. 431/1968 was aiming to consolidate the credibility of the psychiatric hospitals, improving their medical status. Thus, on one hand, the law reinforced the general status of psychiatry as a medical discipline, extending its practice across the wall of the psychiatric hospital, through the creation of a new out-patient service, namely Centro d'Igiene Mentale

[CIM]. In addition, it ratified the inclusion of voluntary treatment and the professionalization of staff. On the other hand, with the justification of improving the standards of the psychiatric hospital, it also ratified a stricter regulation and control that reduced the administrative power of the director in the management of the hospital.

While impacting on the psychiatric discourse, L. 431/1968 had a very limited effect on the legal discourse. Although it ratified the elimination of the penal record, the manicomio was still a security measure, and any person admitted to the psychiatric hospital through compulsory admission still lost their civil and personal rights. This law was also an essential condition for the acceptance of *the second rupture* and the approval of L. 180/1978. L. 431/1968 allowed, in fact, for a new problematization of the psychiatric hospital and psychiatry itself. The attack started in Gorizia hospital was extended to the entire society (chapter IV and V) after 1968: the manicomio was associated with any institution whatsoever (e.g. school, family, factory), and the patients were likened to any minority group (e.g. the poor, black people, women, homosexuals) (chapter IV). Moreover, while during the first rupture, the critique was targeting the medical approach applied in the institutions, which gave scientific justification for the custodial function of the hospital without any real attention to the treatment of the patient, the second rupture was characterised by the complete rejection of psychiatry. In other words, the new aim of the Italian psychiatric discourse was not the formulation of new method or epistemological approaches to mental illness, but the end of psychiatry as a discipline. In this sense, Italian psychiatrists defined themselves as *the last sons of Pinel* (chapter IV). While the former rupture in the psychiatric discourse was aimed at transforming the psychiatric approach, putting the patients at the centre of the relationship, in the latter, the psychiatric discourse took the shape of a movement: Psichiatria Democratica (chapter IV). The anti-institutional critiques were extended across the psychiatric hospital's walls, and they engaged with other national social struggles, such as that of workers asking for better social conditions (chapter V). At the end of the 1960s and in the 1970s, Italy was living through a moment of social protests, and in this context, the legal and the psychiatric discourses found a

common object in the attack on the custodial function of the psychiatric system. While in the system of the 1930s and in the 1960s, the legal discourse was used by the Italian government to reinforce institutional control, in the 1970s a group of magistrates started an alliance with PD with the aim to dismantle the penal system established during fascism. By calling upon the Italian Constitution, the Italian magistrates attacked the double track system and, in particular, the concept of social dangerousness (see chapter V). In this sense, the second Italian rupture was characterised also by a transformation in the legal discourse. The attack of the psychiatric discourse on the psychiatric system and the attack of the magistrates on the penal code created the conditions for the acceptance of the complete abolishment of the psychiatric institutions through the approval of L. 180/1978. L. 36/1904 and L. 431/1969 were repealed and with them also the concept of dangerousness in the legal discourse concerning mental illness. Moreover, with the institution of the public national health system in the same year, L. 180/1978 was absorbed into L. 833/1978, abolishing any special law for people affected by mental illness. It also started a process of decentralization of the management of the psychiatric and health services, in order to avoid the complete control of public service in the hands of one central institution.

DISCUSSION: As seen in chapter II, deinstitutionalization was described as an ensemble of policies (Scull, 1984) aiming to reduce the population of psychiatric hospitals and followed by the creation of new services in the community (Bachrach, 1976). Moreover, this transformation of psychiatric care was acknowledged as an international trend (Goldman et al., 1982) involving most western countries, which started between the 1950s and the 1970s (Novella, 2008). The attempt in conventional accounts to outline a comprehensive model for explaining deinstitutionalization that would be able to include all national variations justified the use of such a broad period for describing the beginning of this process. The present study, by contrast, took this wide unit as a starting point (see chapter III) in order to retrace the multiple discourses that worked in the formation and acceptance of deinstitutionalization in England and in Italy. This enabled the identification of various and contradictory ruptures that worked simultaneously for

the formation of the national discourses at historical moments very different from the ones identified by the conventional accounts. Moreover, my findings showed that these transformations were specific to the national historical contexts. In the English case, for instance, the ruptures that allowed for the acceptance of deinstitutionalization were traced during the two world wars when nationally specific conditions enabled the transformation of the psychiatric discourse and the formation of practices outside of the asylum's walls. It follows that the process of the creation of community services and the extension of the psychiatric practices outside of the hospitals in England started in the 1920s, long before the approval of the Mental Health Act in 1959 and thus before the period at issue in conventional accounts (chapter IV). The present analysis has also pointed out that the creation of community care preceded the decision of the English government to reduce psychiatric beds. Thus, although deinstitutionalization is considered as the process of reduction of psychiatric hospitals, my findings on the English case show that the decision to reduce the psychiatric beds was not a direct consequence of the Mental Health Act 1959, but the result of a calculation made by statisticians in order to improve the efficiency of the NHS. These results are in line with some early studies limited to the process of deinstitutionalization in England, such as the accounts given by Bennett and Morris (1982) and Jones (1972), in which the authors stress the differences between the English case and the American case. Bennett and Morris (1982), in particular, stressed the uniqueness of community care as an English experience. Moreover, Miller and Rose (1988) and Crossley (2006) identified the importance of the period included between the two world wars in the acceptance and formation of the English mental health system.

Although the Italian transformation started in the 1960s, i.e. within the historical period in focus in existing accounts, the archaeological analysis, with its focus on the discontinuities of the discourse formation, enabled the identification of important shifts that linear historical accounts were not able to identify, such as the role played by L. 431/1968 in the acceptance of the deinstitutionalization discourse in Italy. Conventional Italian accounts have read this law as an indication of the progressive transformation of policies toward deinstitutionalization (Babini, 2009).

In particular, Pirella (1987) explained the approval of L. 180/1978 as due to the high costs of psychiatric hospitals after the introduction of the new medical standards of L. 431/1968. The findings of the present study, by contrast, demonstrate that L. 431/1968 was rather a counter-manoeuvre to stop the attack on the institutions, and its approval enabled the re-organization of the attack on the institutions started in Gorizia (chapter V). What is more, costs were introduced in the Italian discourse only during the implementation phase in the 1980s.

This draws my attention also to consider the impact of taking for granted deinstitutionalization as a univocal process, which involved all the western countries on re-writing history. Challenging deinstitutionalization as an international trend allowed for a reading of the transformations in the English psychiatric system from a perspective different to the one applied by deinstitutionalization studies, but in line with the aforementioned studies produced when this idea of deinstitutionalization was still in a phase of validation, (Bennett and Morris, 1982; Jones, 1972), or that were not specifically focused on the process of deinstitutionalization, but concerned with the formation of the mental health discourse (Miller and Rose, 1988; Crossley, 2006). The use of such a comprehensive labelled to the conformity of narrations regarding this change, flattening the various national historical narrations into a univocal one. As seen in chapter II, there is a general agreement among previous accounts on the role played by the introduction of drugs (Jones, 1972; Rose, 1986; Shorter, 1997; Turner, 2004) in the acceptance of deinstitutionalization. My findings, by contrast, agree with criticisms made by Scull (1984), Busfield (1986) and Goodwin (1997) on the minor impact of drugs as the process of deinstitutionalization in England started before the introduction of medical treatments for mental illness. Moreover, although the origins of the Italian psychiatric reform were traced in the 1960s, my findings showed that drugs were strongly rejected by the Italian psychiatric discourse, as any psychiatric practices. Thus, it is not possible to link the origin of the Italian deinstitutionalization to the introduction of new pharmaceutical treatments.

My findings also challenge those accounts that have acknowledged economic reasons, both in terms of costs of hospitals (Pirella 1987; Jones, 1991; Scull, 1984) and in the form of the needs of capitalism (Scull, 1984; Basaglia, 2014b), as decisive for the implementation of deinstitutionalization policies. Although my results agree on the role played by economic conditions in the acceptance of deinstitutionalization, they also show that economic transformations cannot be considered the only element for explaining the movement of psychiatric care from the hospital to the community. Moreover, the application of a cross-national design showed that this element cannot be generalised to all western countries, by using an analytical category as broad as capitalism, as this obscures national differences. While the English and the Italian psychiatric discourses changed at two moments of economic crisis, these were characterised by very different needs. In England, psychiatric expertise was called upon to support an increased need for manpower and a politics of full employment. In Italy, by contrast, psychiatry supported the strikes due to the high level of unemployment and lack of social protection for workers. According to my results, these differences in needs were reflected also in the national critiques of the institutions, which, in the English case, were focused on the inefficiency of psychiatric hospitals, while in Italy they were a symbol of the attack on the whole society that excluded people, rather than providing equal opportunity for all. In this sense, my study agrees with Goodwin's assumption that post-war mental health care policies are more diverse than what conventional accounts illustrate (Goodwin, 1997).

My findings tested also the role played by anti-psychiatric movements and critiques of psychiatric hospitals in the acceptance of deinstitutionalization policies in different ways. First of all, the role of critiques of psychiatry and institutions was presented by most of the accounts on deinstitutionalization as a broad opposition to the psychiatric hospitals that allowed the approval of deinstitutionalization policies (Bennet and Morris, 1982; Turner, 2004). Albeit with different explanations – Jones (1993), for instance, defined them as ideologies of destruction, while Scull (1984) explained that these critiques were used as a justification by dominant groups for the implementation of deinstitutionalization – critiques were presented

by the majority of these accounts as negative and unproductive factors that led to the reduction/closure of psychiatric hospitals without offering any other alternatives (Bennet and Morris, 1982). My findings, by contrast, showed that English critiques were not against the psychiatric hospitals *tout court*, but were a problematization of the efficiency of the entire system. In the Italian case, critiques were not limited to psychiatric hospitals but rather targeted all institutions. Thus, my approach made it possible to analyse in greater depth the contents of these critiques. This allowed for considerations of their role in the formation of new practices and alternative strategies. English critiques, in fact, enabled the acceptance of new concepts, such as mental health and community care, but also the creation of new practices, such as the therapeutic community. In this sense, my analysis is resonant with Miller's (1986) account of psychiatric critique as a "constitutive part of psychiatry" (p.13). Not only did critiques play a role in the problematization of psychiatric hospitals, they also had a productive function in the creation of a new language and practices for the formation of the national deinstitutionalization discourse. On the other hand, my results diverge from Miller's reading of the critiques of psychiatry where he extends his analysis to all western countries. Paying attention to the differences in the national conditions and problematizations of these critiques enabled me to take into account the heterogeneity of the practices that developed from them. While in the English case, critiques to psychiatry took the form of alternative services, the Italian critiques, as a form of rejection against any institutions and psychiatric method, did not develop into any psychiatric treatment in or outside the hospitals, but took the shape of a social and political movement characterised by a series of connections and alliances outside of the medical professional field (chapter IV). Finally, my approach allowed also for a re-consideration of the general tendency of previous studies to assimilate all critiques of psychiatry and institutions under the same label of anti-psychiatry/anti-psychiatries (Jones, 1993; Miller, 1986; Foucault, 2006), without considering the contents and the functions of these critiques in relation to the specific national contexts. My approach allowed me to consider the various national critiques coexisting on the national level and to make a distinction

between them. For instance, my results match with Crossley's analysis (2006) of the mental health movements in England in the distinction between the critiques to psychiatric hospitals developed during the world wars, from the one developed during the 1960s and the 1970s. The former promoted the introduction and development of mental health as a public problem, while the latter characterised the formation of a specific movement, which I will look at in the next section. My outcomes are consistent with those studies that stressed the central role played by Psichiatria Democratica in the Italian psychiatric reform (Ramon and Giannichedda, 1991; Donnelly, 1992; Goodwin, 1997). However, my approach was able also to illustrate the conditions that allowed the formation of such movement and the implications that this unique feature of the Italian deinstitutionalization had for the creation of mental health care practices.

The application of the archaeological method also made it possible to go beyond previous studies which explain deinstitutionalization in terms of progress (Jones, 1972; Turner, 2004) or in terms of oppositions between ideologies (Scull, 1986; Bunsfield, 1986; Jones, 1972). My findings have illustrated that both the English and the Italian cases were characterised by the continual and reciprocal coexistence of more than one strategy, and these strategies were strictly related to their national conditions. Talking of economies of power, rather than explaining social changes as the result of opposite trends, such as epistemological positions (Jones, 1972; Canosa, 1979) or professional struggles (Scull, 1986; Gostin, 1983), allowed me to take into account these multiple and variable interrelations between the different discourses working in the formation and acceptance of the deinstitutionalization discourses in Italy and England. In particular, the application of Foucault's approach to historical research showed its productiveness compared to other approaches when looking at cross-national differences. The next section will focus on these.

In what respect did the formation of the discourses on psychiatric care in the community vary between Italy and England?

While describing the transformations in the English and Italian psychiatric and legal discourses that enabled the acceptance of deinstitutionalization, the previous

section introduced some of the differences between the English and Italian discourse formations. This section will review them more in depth in order to address the second research question. In particular, it will discuss how heterogeneous economies of power impacted on the formation of the national deinstitutionalization discourses and practices, seeking to stress the potential of the application of the genealogical analysis in a comparative study.

As seen in chapter IV and in the previous section, the ruptures in the English and Italian psychiatric discourses, which allowed for the acceptance of deinstitutionalization, were retraced in two different disciplinary systems: the English army and an Italian manicomio. In both cases, psychiatry was involved in power struggles, but with very different functions: in the English case, psychiatric knowledge was called upon as a counter-manoeuvre to the struggle activated by the soldiers against compulsory enlistment; in the Italian context, the new psychiatric discourse, by contrast, developed as a form of resistance against the discipline exercised in the institutions on the patients. Thus, while the former had the function of reinforcing, and rendering more efficient, the disciplinary system, the latter aimed to overthrow it. Findings illustrated that these differences took the shapes of dissimilar critiques of the psychiatric institutions. In the English case, they problematized the efficiency of long-term admissions, proposing early intervention for those cases that were still recoverable as the most effective strategy (chapter IV and VI). In the Italian discourse, by contrast, critiques were a proper attack on the manicomio and their custodial function, not in economic or medical terms, but as a symbol of the juridical system established during fascism (chapter V). This difference is not just an epistemological one; the findings did not just describe two different ways of facing a similar problem, but two different problematizations with dissimilar strategies inserted into two distinct economies of power.

The application of a cross-national comparative approach, focused on these differences rather than on trends and similarities, allowed me to illustrate how even parallel practices, when included in different economies of power, take very distinctive functions and shapes, such as in the case of the therapeutic community

(chapter IV and VI). As seen, the English therapeutic community was directly funded by the British government in relation to the political strategy of full employment implemented in England in 1944. It aimed to improve the efficiency of the psychiatric institutions, to make neurotic soldiers productive again while they were still in the hospitals. In Italy, the therapeutic community was implemented not in the attempt to establish a new therapeutic method or to improve the efficiency of the system, but as a first step towards the abolishment of the psychiatric hospitals, with the overthrow of its hierarchies, alliances, and divisions. While in the former case, psychiatric expertise worked in a reciprocal relationship with the governmental strategy, in the second case, the government was not an element in the negotiation of psychiatric transformation, but rather an institution to resist, much like the manicomio itself.

These findings were not limited to the psychiatric practices, but similar differences were retraced also in the transformations of the legal discourses and practices. One of the most evident differences between the English and Italian ruptures concerning the management of mental illness concerned the national ruptures of the 1930s. The period after WWI marked an important moment in the formation of the national governments in both countries. While the English and Italian political strategies shared the objective to rationalise the system concerning the management of insanity through the application of new expertise, and *prevention* was at the core of these tactics (chapter V), they took very different shapes in relation to the national government rationalities. While in England, this period saw the approval of the Mental Treatment Act 1930 with the introduction of voluntary and temporary treatments and outpatients' services, in Italy, by contrast, the Rocco code was approved, with a further tightening of psychiatric hospitals as custodial measures. The former led to the acceptance of the treatability of mental illness and the introduction of medical discretion into the legal discourse, the latter, by contrast, consolidated the medical-juridical discourse with the introduction of the safety measure and the legal notion of social dangerousness. Retracing these differences represented a major contribution to the understanding of deinstitutionalization for different aspects. Deinstitutionalization has often been

described as the result of a process of medicalization of mental illness (Conrad, 1979), an attempt to rationalize strategies of control (Rose, 1986; Castel, 1991; Scull, 1983), and the outcome of the development of medical progress (Jones, 1972). To a certain extent, these strategies were active in both countries: the English and Italian governments justified their new political strategies as due to progress and medical advancement. On the other hand, the focus on the cross-national differences enabled me to describe how different rationalities and conditions can lead to the acceptance of very different types of knowledge and the formation of sharply contrasting practices. In England, the focus on improving the efficiency of the system was read in terms of reduction of cost and enhancing the productivity of the population, and it was correlated with the acceptance of the social psychiatry discourse and the problematization of the psychiatric hospitals. In Italy, by contrast, the rationalization of the system in relation to the aim of safeguarding the state led to the acceptance of the positivist approach to mental illness and the reinforcement of the role played by the manicomio, rather than its problematization. These elements cannot be underestimated in their importance for the comprehension of the formation of the Italian anti-institutional discourse, as they created very different conditions for the formation and acceptance of the critiques of the psychiatric hospitals. If we constrain our analysis by applying these overarching analytical categories, such as medicalization, we fail to capture these differences.

As seen, conventional accounts ascribed a central role to medical progress in the implementation of deinstitutionalization policies (Jones, 1972; Turner, 2004; Busfield, 1986). My findings challenge the universality of knowledge and medical progress not just in relation to the type of epistemological approach accepted in similar periods by different countries, but they also showed that different conditions can be characterised by different forms of validation of knowledge. Chapter IV showed that the recognition of concepts, such as emotional shock and predisposition, which were essential in the new English psychiatric discourse, followed the inclusion in an official document produced by the army. These concepts were investigated and corroborated by *the most authoritative experts in*

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the field (chapter IV). The process of institutionalization of these concepts was thus characterised by a top-down process of validation. The acceptance of the new psychiatric discourse in Italy, by contrast, had as the main feature a bottom-up process: although the struggle was initiated by experts, it was validated by the experiences of the patients and accepted by public opinion. The process of validation of knowledge was strictly related to the problematization and strategy of the Italian psychiatric discourse that rejected any form of institution, including academic official documents, favouring forms of communication meant for the masses, such as radio.

My findings illustrated that these differences in the process of validation of knowledge were also reflected in the type of knowledge produced and the tools created to collect them. In the English psychiatric discourse, patients were the subject of study and analysis, in order to produce knowledge on mental illness and its treatment. In Italy, by contrast, patients became an active part in the production of truth on the institutions. An example of this difference can be elucidated with reference to the different uses of *interviews* in the creation of knowledge. As seen in chapter IV, the transformation of the psychiatric discourses in both countries led to a transformation in the role played by the patients in the relationship with the psychiatrist. While traditional psychiatry was based on the observation of the body, the new psychiatric discourses gave voice to the patients. In both cases, *interviews* had a central function in the production of truth, and they enabled the acceptance of a different approach to mental illness and the patients affected by it. In the English case, interviews were introduced as a new technique in relation to the acceptance of a psychological approach to mental illness. They were applied as a new technology of control in the management of the epidemic of war neuroses among the soldiers, and to expand knowledge on illness and the subjects affected by them. In Italy, by contrast, interviews with patients were published to raise awareness about the violence to which patients affected by mental illness were subjected in society and in the manicomio. Interviews were conducted in the hospitals also by journalists, not just with patients but also with staff, as they were not aiming to produce new knowledge of the illness, but rather a knowledge of

society as a whole. Thus, psychiatrists and patients became the owners of truth, not in relation to illness and its symptoms, but because of their shared experiences of life in the manicomio and individuals subjected to the power of the institutions – albeit in two different ways. My findings regarding the English case and the use of the interviews reflect the account given by Miller and Rose (1988) in the analysis of the Tavistock experience but also underscore the limitations of extending such analyses to all western countries. The application of genealogy in a comparative study enabled the avoidance of such generalizations and the extension of understanding of the contemporary psychiatric practices retracing intersection points or divergences.

The limitations of considering deinstitutionalization as a process involving all western countries also include the limitation of considering all international critiques under the broad label of anti-psychiatry or anti-psychiatries. The Italian case showed that the psychiatric discourse started by Basaglia at Gorizia, in fact, cannot be reduced to a "line of critique of the asylum" (Miller, 1986, p.22), as this would reduce them to a univocal type of struggle. Findings showed that Italian critiques were not limited to the psychiatric and institutional setting, but they must be included in a larger protest against the system that was established during the fascist period, and, as such, they were strictly related to the Italian historical context. As seen, in the previous section findings illustrated the coexistence in the English discourse of multiple critiques of psychiatry and institutions, highlighting a distinction between critiques of efficiency and those of the anti-psychiatry movement. In this sense, here it is interesting to point out how the Italian PD differed from the English anti-psychiatric movement. According to Crossley (1998a), the anti-psychiatric movement in England was different from the previous critiques of institutions in that the movement was characterised by an awareness "for itself" (p.878). The subjects of its criticism were psychiatry, and this was characterised by a strong radicalism on the matter. Attention was paid to the wider society, but the critique was not explicitly political. Moreover, the movement was described by the author as a revolt from above, "within the ranks of psychiatrists themselves" (p. 878), followed by the development of a revolt from below, but these were distinct.

My findings clearly have some similarities with this analysis of the English anti-psychiatric movement. But PD was a different movement. First of all, the revolt from above was parallel to the revolt from below; they were part of the same process. Secondly, the Italian psychiatric movement extended the subject of its struggle from psychiatric matters to the entire society, and this was not just a secondary element but it became the main objective of the whole movement (see statute in chapter IV). This was also stressed by the use of PD of a language inspired by Marxist theories stressing the political rationale at the core of the movement. As noticed also by Crossley (1998b), this was not used by the English anti-psychiatric movement.

The attention paid to the identification of the different national struggles at the basis of the critiques and of the formation of the national deinstitutionalization discourses must be not read just as a theoretical exercise. It also made possible the comprehension of the differences in the formation of the national health systems. As seen, in both cases the complete integration of the psychiatric services in the general medical system and the implementation of the services in the community was strictly intertwined with the creation of the national public health systems (chapter V). However, while in the English case the NHS was to a certain extent the completion of the process of centralization, in the Italian case, the birth of the SSN and the approval of L. 180/1978 marked the institutionalization of regions as a new level of governance, ratifying a process of decentralization of the control of health services (chapter V). While the acceptance of the mental health discourse in England enabled the reinforcement of the central power of government through the multiplication of expert functions, in Italy, by contrast, experts supported the fragmentation of power among different levels of governance. Findings concerning the English case are in line with the readings made by governmentality studies that acknowledged the role played by psychiatry in offering a new language to the state to justify the process of rationalization. On the other hand, these outcomes cannot be used to explain the Italian transformation, too. As seen, the two national psychiatric discourses formed through different struggles and strategies. Central power and the concept of the state over anything were essential elements of the

fascist political strategies and, as such, were subject to the attack of the Italian new psychiatric discourse. Decentralization and the institutionalization of regions must be read in relation to this difference.

The application of a cross-national design of the genealogical approach enabled to stress and analyse the differences in the strategies, needs and conditions that led to the formation of the discourses on deinstitutionalization. This allowed also to highlight how these differences led to the implementation ofthe dissimilar psychiatric system. This is what will be discussed in the next section.

To what extent have differences impacted on national practices concerning mental illness?

Findings in the analytical chapters and the previous section have already illustrated how heterogeneous national needs and problematizations enabled the acceptance of very different practices. Chapters IV and VII illustrated, for instance, the differences in the national problematizations at the core of the therapeutic community, and how this allowed different uses of the *meetings* as psychiatric practice. Chapter VII, by contrast, discussed how the implementation of national tools for the assessment was related to two distinct strategies, improving the efficacy of the institution in the English case and validating L. 180/1978 in Italy, and how these dissimilarities led to the production of very diverse types of data. In order to address my third research question, but also showing the potential of my method for understanding the differences among the national mental health care systems, this section will explain, on the basis of my findings, one of the most visible differences between the English and Italian psychiatric systems: the presence of psychiatric hospitals.

As seen in chapter V, one of the main distinctions between the English Mental Health Act 1959 and L. 180/1978 was that the latter prohibited the institution of any specific buildings, or special units into general hospitals, as custodial places for psychiatric patients. The Mental Health Act 1959, by contrast, reiterated the necessity of exclusive spaces for the custody of psychiatric patients who required compulsory treatments. The decision to reduce the availability of psychiatric beds

was the result of a political strategy concerning the re-organization of the cost of the NHS and implemented in relation to the approval of the hospital plan in 1962. Although previous studies on deinstitutionalization acknowledged this difference between the English and the Italian mental health systems, this feature has been mainly addressed as a radical element of the Italian deinstitutionalization (Goldman et al., 1982; Bennet, 1985) and analysed as a difference in the hospital bed rates (Fackhouri and Priebe, 2002; Medeiros et al., 2008). My findings suggest that this trait is the evident sign of the fact that it is misleading to consider the transformation of the Italian and English psychiatric system under the same name. The Italian and the English deinstitutionalizations cannot be considered as two extremes of the same process, but must be seen as two distinct transformations and, as such, an assessment of the two implementations based on the distribution of beds and services is based on a distorted assumption. My investigation challenges this way of approaching this matter because my results show that the Italian political decision to abolish the existence of the psychiatric hospitals[56] cannot be explained only as a difference in the grade of deinstitutionalization. It was a strategy completed different from the strategy implemented by England. The application of a cross-national genealogy of the national deinstitutionalization discourses allowed me, in fact, to describe the differences in the struggles at the basis of the formations of such discourses, challenging also those approaches that look for the definition of comprehensive models and explain deinstitutionalization as an international trend.

Chapter V argued that in the period before the first rupture (see Figures 6 and 7) in both countries segregation was compulsory in relation to the dangerousness of the patients affected by mental illness, and the existence of the psychiatric hospitals, as places of segregation, was justified in relation to this idea of mental illness. The English ruptures that led to the transformation of this system were characterised by the attempt to improve its efficiency, but these changes left the idea of the dangerousness of the psychiatric patients almost untouched. Thus, the approval of

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[56] It is interesting to point that this strategy has been completely implemented in 1996, with the total closure of all the psychiatric hospitals.

a special law, namely the Mental Health Act 1959, for the treatment of mental illness was justified by the special feature of mental illness, which, even if only on rare occasions, still requires the coercive power. In the Italian case, by contrast, the discourse originated from the attack on the previous system established during fascism. In particular, the notion of the social dangerousness of the patients affected by mental illness and the existence of the psychiatric hospital as a safety measure to prevent dangerous conducts were acknowledged as the core of this system, and, as such, they became the main objects of this attack. L. 180/1978 was the representation of this rejection with the abolishment of the psychiatric hospitals and the idea of psychiatric patients as dangerous. This difference is reflected not only in the existence of the psychiatric hospitals but also in the rationale at the heart of the compulsory treatments provided by the Mental Health Act 1959 and L.180/1978. While in the English discourse, a special law providing this power was still necessary in relation to the aforementioned feature of mental illness, in Italy, the existence of compulsory treatment was justified as an extreme measure to apply in relation to a lack of adequate alternative services for the patients' need when in crises.

While invalidating those analyses looking at deinstitutionalization in terms of bed rates, my findings were in line with the main literature on governmentality, which explains the transformation of psychiatric discourses and practices in relation to changes in government strategies. My findings also point out the limits of this approach when generalising the analysis of deinstitutionalization practices to all western countries. An example of this analytical weakness is the application of the notion of risk to explain the formation of community services. While in the English context, the application of such notions for the analysis of the mental health policies was very productive (Castel, 1991; Rose, 1998), in the Italian case, the elimination of the concept of dangerousness in relation to mental illness made this notion irrelevant.

CONCLUSION

This thesis offers strong indications evidence for applying cross-national comparisons of the formation of national deinstitutionalization discourses for the comprehension of the differences in the national mental health system. The rejection of the assumption of deinstitutionalization as an international trend, and paying attention to the economies of power rather than using overarching analytical concepts, such as social control or medicalization, allowed me to outline a more complex picture of the multiple discourses interacting in the formation of the community care discourse. Findings illustrated that this shift in psychiatric care was not a straightforward process, but was related to multiple ruptures and historical conditions that were closely tied to the national context. The comparison of the English and Italian deinstitutionalizations did not just enable me to write a different history from the one outlined by existing accounts, but it also allowed me to question taken for granted truths around this change, such as the notion of the role played by the introduction of drugs or the idea of anti-psychiatric movements of the 1960s and 1970s as an international trend. Moreover, this research has also shown that different needs and historical conditions can lead to the formation of very dissimilar problematizations and discourses and that similar practices can be based on very different assumptions. Findings illustrated during this thesis showed that the shift of psychiatric care from the hospital to the community in Italy and in England was due to very different conditions, needs and political strategies. In this sense, the result has been that the differences between the Italian and English national mental health care systems cannot be explained only as the products of cultural differences, but they are the evident indication of the fact that the process of deinstitutionalization was not a univocal trend among the western countries.

One of the most striking outcomes of this study was that the processes that led to the movement of psychiatric care from the hospital to the community in the two countries cannot be described with a univocal term. My analysis pointed out that in the Italian and English cases it is more accurate to speak of different processes, or at least of deinstitutionalizations, using the plural. In this sense, studies using bed rates or the distribution of services in the community as criteria to evaluate the

level of deinstitutionalization of a country are challenged, as they are based on a misleading analytical category, since the two political strategies had very different aims. On the other hand, it is important to stress that this study was limited to only two countries and for this reason, my results cannot be generalised. The Italian case has always been recognised as one of the most radical implementations of deinstitutionalization, and for this reason, it would be interesting to extend this analysis also to other countries. The application of this method can allow the identification and description of international similarities and differences among the multiple rationalities that worked at the formation of the present mental health care systems. In this sense, it appears that a fruitful approach would be to extend this study to include the most recent transformations of the Italian and English psychiatric discourses, in particular in view of the findings illustrated in chapter VI concerning the impact of the supranational dimension on the Italian discourse.

It is important to reiterate that the aim of this study was not to provide an evaluation of the national implementation of deinstitutionalization. My work does not offer any advice on how to improve services or policies, but the conviction underpinning this analysis was that a better understanding, or the possibility to look at things from a different perspective, can help "to reshape and expand the terms of political debate, enabling different questions to be asked, enlarging the space of legitimate contestation" (Rose, 1999, p.277). In this respect, there is another contribution of this study that is worth emphasising in this context: it enabled me to reconsider the role played by experts in rewriting history. As seen, the introduction of the idea of deinstitutionalization as an international trend in the 1980s impacted on the way this was studied; it enabled the increase of comparative analysis, but also the reconsideration of national histories. My study demonstrated that English and Italian national implementations of deinstitutionalization are not the results of the same process, but they were characterised by different objectives and values. Examining deinstitutionalization as not only one way of taking care of psychiatric patients, but as an ensemble of multiple discourses and practices can lead to a new mode of looking at the differences between national mental health care systems.

This would challenge also the actual use of universal indexes, such as the community integration index.

APPENDIX

List of abbreviations

Italian legal documents

Cost.= Costituzione della Repubblica

C.p.p.= Codice di procedura penale

D.P.R.= Decreto Presidente Repubblica

L. = legge;

R.D. = regio decreto;

Reg. = regolamento.

Sent. = sentenza

Art. = articolo

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