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Editorial

How Law 180 in Italy has reshaped psychiatry after 30 years: past attitudes, current trends and unmet needs

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Summary
Law 180 eliminated psychiatric hospitals for the care of people with chronic psychosis in Italy. After 30 years, we review the consequences for the practice of psychiatry in Italy and parallels for England and Wales. We argue that the substitution of legal/political direction for clinical leadership means psychiatrists may cease to merit the privileges and responsibilities of being doctors.

Declaration of interest
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Italian Law 180, 'The Reform of Psychiatric Care' approved in 1978, was unquestionably a historic legal landmark. For the first time in Italy, the dignity of the acutely ill patient, rather than the need for their restraint, was made the central focus of a statute to change medical intervention for the mentally ill. It concerned primarily those in-patients who made up the population of old style, long-stay psychiatric hospitals, usually with chronic psychoses. Its vision – to improve the welfare of the vulnerable by preventing their indefinite detention in poor-quality in-patient facilities – was exemplary. However, great visions and good intentions are no guarantee of a good practical outcome. We wish to ask the question whether reforms of this kind should be driven from a particular political position by the exercise of political power, or whether they can be harnessed to improved codes of practice driven by experts from within the community of health professionals and informed by science, evidence and the experience of patients.

By requiring the exclusive management of mentally ill individuals outside psychiatric hospitals, Law 180 imposed a political position that confused the effects of severe mental illness with the effects of institutionalisation *per se* and underestimated the challenges for clinical care in community settings. Implementation was partial and slow because of chronically poor financial support,[1] and the need for long-term care[2] was underestimated. It did not address therapeutic and rehabilitative interventions and ignored the anxiety and mood disorders.[3] Its impact on the present state of Italian psychiatry has been rather negative, and bears comparison with similar changes in practice highlighted recently in England.

Current trends: the loss of medical skills

The elimination of public psychiatric hospitals reduced the scope of psychiatry 'in the community' in Italy. People with depression or with anxiety disorder now consult private clinics and psychologists; they do not identify themselves with routine psychiatric services. Thus, recent generations of psychiatrists in Italy possess a limited knowledge of anything but individuals with chronic psychosis, who form the great majority of the patients under their care in the psychiatric wards of general hospitals and in their out-patient departments. Psychiatrists now adopt an essentially managerial approach, ignoring diagnosis and the clinical formulation of problems in the treatment of the individual. The overemphasis on the social care of psychotic disorder has reduced attention to clinical phenomenology, diagnostic discrimination and the study of symptoms in their cross-sectional and longitudinal dimensions. It has coarsened the choice of pharmacological and/or psychotherapeutic treatments (in regards to, for example, the prevention of suicidal behaviour,[4] aggressivity in bipolar disorders, cognitive function as it relates to outcome or other predictors of clinical response) and their mutual integration. The aetiology of the psychoses, revealed in the last decades to be complex phenotypes resulting from the interplay of genetic and environmental variables[5–7] is poorly understood. The biological, brain-based analysis of psychological and even social aspects of behaviour are ignored.

Professionally, psychiatrists have almost lost their medical identity and become instead bureaucrat, social worker or manager in the field of mental health. People who are acutely ill are sent to services exclusively on the basis of residence, rather than competence and it is now common for situational disturbances to be confused with mental illness.

The absence of a biomedical perspective to clinical management perpetuates public ignorance and denies facilities to these disorders, which are not seen as meriting medical prioritisation. There is a failure to utilise integrated treatment approaches across the whole range of mental disorders and little reference to internationally recognised treatment criteria (e.g. American Psychological Association or National Institute for Health and Clinical Excellence guidelines), which are often believed, quite erroneously, to support pharmacological treatments, when the use of other clinically important interventions have also been evaluated.

Parallels with the English experience

Basaglia's conceptual justification for Law 180 derived from the Anglo-Saxon social psychiatry of the 1960s. This had a pragmatic

face expressed in the work of John Wing, George Brown, Julian Leff and others who saw social science as just that, an observational science that could explore hypotheses, seek causes and provide reliable knowledge. The Italian experience was actually often invoked positively to validate the voluntary movement to more 'community care' in England, which was ongoing from the 1970s. In fact for many years, large remote asylums had seemed dehumanising and were regularly the cause of minor scandals. Enoch Powell was an energetic and reforming minister of health who memorably described his vision in 1961 (http://studymore.org.uk/xpowell.htm): speaking of people who are mentally ill he said:

'Few ought to be in great isolated institutions or clumps of institutions, though I neither forget nor underestimate the continuing requirements of security for a small minority of patients.

'Now look and see what are the implications of these bold words. They imply nothing less than the elimination of by far the greater part of this country's mental hospitals as they exist today. This is a colossal undertaking, not so much in the new physical provision which it involves, as in the sheer inertia of mind and matter that it requires to be overcome. There they stand, isolated, majestic, imperious, brooded over by the gigantic water-tower and chimney combined, rising unmistakable and daunting out of the countryside – the asylums which our forefathers built with such immense solidity to express the notions of their day.'

Community care was the buzz word of the 1990s and became government policy under the then Conservative government: directed with memorable self-confidence by one health minister who had been a social worker. Labour, once in power from 1997, rhetorically declared the previous government's policy of community care to have failed: their solution was the National Service Framework in England (NSF).

The NSF is a hybrid document. Some of its content is simply good clinical practice, with which no one would argue. However, the casual description of multiple, fractionated service models piloted only in local showcase projects has mutated over time into a remarkably rigid blueprint for how care should be provided by every trust in the country. This micromanagement is literally enforced through arbitrary targets. Moreover, the only big idea – that psychiatry is the provision of social care – has driven the formation of larger and larger mental health trusts, detached from other medical services. This has had echoes of the isolation of the old asylums, intellectually if not physically. Mainstream psychiatry was deliberately marginalised in writing the NSF. The negative consequences for the practice of psychiatrists in England and Wales have been identified by the wake-up group[8] and uncannily echo the Italian experience.[9]

Conclusions

If psychiatrists are to remain doctors, and claim the privileges and responsibilities of doctors, they should be committed to a life-long process of learning, adaptation and leadership. This means practice of proper skills and role, focusing on early and accurate diagnosis, assessment of comorbidity and implementing the most modern, innovative and evidence-based treatments. Their prime professional responsibility is to treat their patients as well as they can. The situation in both Italy and England has in culturally specific ways converged on the same solutions to the imposition of a legal/managerial rather than clinical framework. In neither country has the professional responsibility of doctors to implement good practice been made the driver of reform. In England the concept of clinical governance has actually relieved doctors of critical clinical responsibilities. In Italy the change has been more passive. In both countries, the profession of psychiatry is at a crossroads. We believe psychiatrists should reclaim their medical role as leaders of services and innovators. If they fail to do so, quite simply they have no future.

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