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At the intersection between the intimacy of individual stories and the public places we inhabit. A dialogue with Benedetto Saraceno

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Fabio Vanni,* *Mauro Mozzani***

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Fabio Vanni: Good evening, everyone, and a big welcome to Dr. Saraceno. I would like to start this dialogue with Dr. Mozzani and myself with an almost obvious question-analysis in some respects. "Where are we with mental health today in Italy?" Since many years have passed, almost half a century in fact, since Law 180 was passed and we know how many critical elements, more generally on the issue of health, but in particular on mental health today, are concentrated and increasingly present in this area, I believe that your opinion could introduce us to the heart of the matter.

Benedetto Saraceno:[1] Good evening everyone, and before answering Dr. Vanni's question, I would like to thank my colleagues who invited me to this dialogue and all the organizations behind this evening's event.

*Director of the Ricerca Psicoanalitica Journal, President of 'Progetto Sum ETS' and of the 'Network for Social Psychotherapy', Italy. E-mail: fabiovanni@progettosum.org

**Psychiatrist, Head of the Department of Psychiatry District of Fidenza – PR. Psychotherapist, member of the 'Sum ETS Project', Italy.
E-mail:mozzanimauro8@gmail.com

[1] Benedetto Saraceno, psychiatrist and public health expert. He has worked with Basaglia and Rotelli in Trieste. Subsequently, he directed the Laboratory of Epidemiology and Social Psychiatry of the Mario Negri Institute in Milan. For many years he headed the Mental

The first question you ask requires a rather complex answer. "At what point are we? Where are we?", we are still better than the rest of the world. That is, in other words, with all the criticisms and reservations you may have about the declining situation of the quality of mental health services in Italy, for some years now, when comparing these services, even average ones or not particularly good ones, with average and not particularly virtuous services in the rest of the world, and I am thinking not of low-income countries but also of high-income western countries, we are still basically at the top of the class. That's the good news, the bad news is that we're much worse off than we were ten years ago, fifteen years ago or twenty years ago, that is, the conquests that were made since Law 180 have given us, how can I say, an incredible advantage in this bike race, so even if we keep losing miles upon miles, we are still in the lead, but we need to know that we are in a situation of great decline and we are losing a lot of miles every day. So, the answer is we are good compared to others, but we are not so good compared to ourselves.

Fabio Vanni: It would be useful then if we could start to talk about the reasons for this decline and perhaps also about what direction we could take to reverse this trend which, undoubtedly, may not continue to keep us in first place, not that it is a race, but because the quality of care is of interest to everyone.

Benedetto Saraceno: I believe that there is an answer that is easily accepted by all because it finds a guilty party outside of ourselves, that is, if the answer is that bad governments have mismanaged this cultural heritage after the Law 180 (the great reform) and that in the regions, the less virtuous regions, the more virtuous ones, the bad ones, or the very good ones… the blame lies with the policy makers. Local policy makers, regional policy makers, and the general regressive political cultural climate, which above all erodes the public health system far beyond psychiatry. All of this is true, but in my opinion, it risks being a bit of a confusing factor with regard to the responsibilities of mental health workers, because to say that there is a crisis because the government is bad, and because of poor governance in the regions etc., is a partial response that somehow does not make a reason for a cultural involution; a cultural involution of the operators. One might say that this setback is linked to a general setback of policies and that it is therefore the policies that have yet again motivated the progressive demotivations, the progres-

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Health and Substance Abuse Department at the World Health Organization in Geneva. He currently chairs the Board of the Lisbon Institute of Global Mental Health. He is the author of essays and monographs including «The End of Entertainment» and «On the poverty of Psychiatry».

sive privatization of services… you can say what you want, but I believe that mental health workers are certainly returning to a more performance-oriented attitude than a care-oriented one today. The attitude of the operators is to recognize on an etiopathogenic level the weight, the importance the impact, the significance of the so-called social determinants, but this recognition is an academic recognition, it does not translate into intervention on social determinants. Here, too, there is an excuse that is used very often by mental health workers who say: "we can't do anything about social determinants", and if you go and look at classic public health texts the social determinants are poverty, conflict, war, unemployment, gender differences, the cultural levels of the population, and they say, "well what can I do about it? I am an operator of that service, and I won't be able to change these social determinants." Psychiatrists and workers are certainly not asked to reduce poverty or increase the cultural levels of the population, there are social macro-determinants on which operators are certainly powerless, and rightly powerless, but there are micro-determinants on which operators have the opportunity to intervene, by micro-social determinants I mean the micro family, economic, social, psychosocial contexts of individual patients which involve possible remedial or improvement interventions. So, I get the impression that operators today are definitely returning to a self-accountability, especially a clinical, biomedical, biopsychomedical one, if we want to play with words, but that basically everyone here, if we were to ask the room here tonight if they thought that social determinants were important in determining psychic and mental disability and in the natural history of mental illness, everyone would say, "of course, yes, we know, we know that being poor is different from being rich, that going to school is different from not going to school, that being a single mother of three children is different compared to being a mother with a family, that is more structured and functional, etc.", we all know this. The issue is not whether we know this, the issue is not whether we are aware of this etiopathogenic role, but whether our services are active and operative in modifying micro-social determinants. My feeling is that maybe it would be worth not saying "damned government!", that is, that services are bad because there is privatization and that there is an erosion of human resources. All these things are absolutely true, and we must be conflictual regarding them and defend the public service and the resources associated with it, but at the same time we must not escape a self-critical reflection that says, "am I really working all-out in the services I am offering?" That famous "complete intervention" to use the famous expression by Carlo Manuali at the time of the reformations in Perugia or the microareas, an invention from Trieste, or in any case all those interventions even outside of Italian psychiatry that are assertive interventions, that have the capacity to change the contexts of patients and their families. I have the impression that psychiatry today is hiding behind the DSM 5 of psychopharmacological techniques, that are usually

of low quality, and psychotherapy techniques, which in most cases are generic psychological aids that are not particularly sophisticated. So, my answer is: this crisis is due to strong cultural responsibilities and to our own cultural regression, which does not mean there are responsibilities that are not ours and that are more linked to politics and policies.

Mauro Mozzani: Good evening, Dr Saraceno, I am Mozzani; I want to go back to the problem 'psychiatry versus social determinants'; in your latest writings which I have read I was very much in agreement with the need to develop networking, with the social aspect and with all the bodies and components surrounding psychiatry. But does this not run the risk of putting mental illness back in parentheses? I know this is a rather provocative question. The second question is whether this historical passage we have seen in recent years, which is characterized by a progressive loss of strength of the ideas and ideals of Law 180, is not also linked to profound social changes that have taken place over the years and that we can no longer frame in that social fabric where Law 180 was born? It was born at a time when there was the opposition of the Communist Party with the Christian Democracy Party, of the Moro kidnapping, followed by the 80s of Craxism and so on. In short, with political, economic and social processes that have now profoundly changed. Now we have legions of young people without jobs or who have temporary work, a profound change in political and social structures, a return to poverty, and mass immigration: do these social aspects not also force us to reflect on the ideas contained in Law 180?

Benedetto Saraceno: So, you ask two questions, dear colleague: one, should we put mental illness back in parentheses? No, we can remove or put parentheses as we wish, but the question I ask you is this: "if we remove these parentheses and deal with mental illness, do we really have instruments that are competent and transformative?". That is, the epistemological solidity of psychiatry was fragile in Husserl's time, it was fragile in Jaspers' time, it was fragile in Basaglia's time, and I don't get the impression that today the epistemological construction of the DSM 4, 5 or whatever, rather than psychiatric interventions are much more robust on an epistemological level and also on the level of the outcome studies which, alas, always show that 1/3 is better, 1/3 is worse, and 1/3 is the same, and that then whatever you put in the barman's cocktail basically a third of cocktail drinkers vomit, a third is happy, and for a third it's as though they haven't had anything to drink at all. This dramatic stability of outcome and epidemiological studies must make us think about how removing or placing the parentheses is not an ideological operation. I would be happy to remove the parentheses of mental illness, in the sense that Basaglia, not being an anti-psychiatrist, never said that there is no mental illness, he said, 'I put it in parentheses

because I deal with the sick instead of the sickness', but somehow Basaglia's radicality, unlike that of the English anti-psychiatrists, is not in saying 'mental illness does not exist', which Basaglia never said, but it is in saying that it is psychiatry that perhaps does not exist. It does not exist in the sense that it carries an extremely dubitative, dubious, very unstable, unreliable construct. So, I'm very happy to take away the mental illness parentheses with you, the problem is, «what next?» that is, once we take them away what we do? We're still prescribing psycho-pharmacological drugs like laymen, psychotherapies too, the evidence of which is somewhat doubtful, at the very least, and services that pose the question "where do I put the patient? What do I do with him/her?» So, it's all very well to remove these parentheses, as long as we know what to do. If you, I mean you as a hypothetical operator, have a very clear idea of what to do, it is all very well that you remove the parentheses. With regard to your second reflection on the changed context, I very much agree with this. However, a distinction has to be made, and that is, I agree that we need to think about, for example, the word community, which we abuse by continuing to talk about community services, community intervention. I believe that we should understand what a community is today compared to fifty years ago. I think that very often we have in mind a romantic idea of community, that is, as a well-defined geographical place where there is, as it were, community homogeneity, there is the doctor with a white beard, there is the pharmacy, there is the church, there are the people, there are the young people, the elderly and the workers and this is the community, but this community does not exist, it is an idealized community. What is the community like today in a city such as Naples or Los Angeles? What is a community like today when proximity is much more virtual than geographical between people? There's a nice study done by American sociologists on a huge sample of the population in Los Angeles, starting with this issue: you go to the doctor who tells you that you have a very serious tumour and that you have a few months left to live. This is news that upsets you, that evidently changes everything in your existence. Once you've left this appointment with the doctor, who is the first person you contact? This was basically the central question of the survey, and the impressive response is that more than 80% immediately contact people who are more than 500 kilometres away. So, they don't contact the community, there's no mom, there's no dad, there's no brother, there's no aunt, there's no neighbour, the geographic community does not exist; nobody says, "I'll go home and talk to my Pastor", there is no Pastor, people send an email across the coast in the United States to talk to their sister or friend. This is to say that actually the community today is increasingly virtual and is much less a spatial and physical contiguity, and that changes everything. So, I agree with you that, today, with the tools with which we navigate in the community and in the demand for health or in the topic of suffering, that the

community formulates for us, things are different compared to the times of Franco Basaglia in Trieste. In Trieste, when a patient escaped from the asylum, you would find him at the Inn, the police knew him and re-accompanied him back to the asylum. There was still a contiguous community and somehow it was easier, in some ways, so I share with you that it is not a question of resting on the laurels of the Law 180, which is treated as a magical and virtual object, but I am increasingly convinced, and this comes from 20 years of working in seventy countries of the world in contact with the Arab, Eastern, Chinese, Japanese or Latin American psychiatries, that the question of the social determination of psychic suffering is constantly there. It's always there, and it's constantly there, questioning us. It certainly questions us in different forms, in the sense that probably youth problems have changed their appearance, there are some interesting studies on suicide that show that the suicide profile today compared to that of forty years ago is very much modified. So, I agree with you that it is not a question of celebrating or monumentalizing Basaglia, Trieste and the Law 180; I do not care for this, it is about today. It is a question of looking at what the requirements are, but also at what miserable level psychiatry is at around the world and also quite miserable in many parts of Italy. This is a fact that is there and that we question today. So, I don't consider the question of parentheses provocative, in the sense that it's a good thing to remove these parentheses, in the sense that it's necessary that epistemologies - plural, as Anne Lovell rightly says, who conducted interesting studies and essays on psychoanalytic epistemologies, psychiatric epistemologies, the epistemologies of interventions on disabilities - they are different epistemologies. To the extent that these epistemologies speak, dialog and integrate, we probably also discover new paths that allow us to remove these famous parentheses. I do not know if I have been sufficiently, how can I say, satisfactory in answering these questions, which are extremely challenging.

Fabio Vanni: I will return a little to your initial response, because it seems to me that you quite rightly highlight, a tendency, I say this very concisely, to an individualistic technicism, which is also perfectly in tune with what is happening in the world of health in general, not only in psychiatry and mental health. So, since we are thinking and hoping for a shift to a dimension where, let us say, more psychosocial competencies have greater relevance, it seems to me that we are really in a situation of great difficulty, because it is as if, in following this path, which you yourself have denounced a little, I think we're at a dead end. I mean, if we need to focus more on microsocial determinants, we need skills that are a long way from what mainstream psychiatry can do today. Because it seems to me that it is part of a paradigm which is that of current medicine, which unfortunately is increasingly moving towards a, let us say, biocentric direction. You put psy-

chopharmacological intervention and psychotherapeutic interventions on the same level: I would like to point out that the space that psychotherapy has in mental health in Italy is perhaps one in a hundred compared to pharmacological interventions.

Benedetto Saraceno: I absolutely agree with you. Let's start with the fact that I have a lot of admiration for an English epidemiologist named Helen Killaspy who has conducted studies that have shown very solidly and convincingly that the increase in new techniques, the increase in services that are specialized in pathologies, clinical conditions, for the natural history of diseases, that is, disease-oriented services, or phase-oriented services - for acuity, for chronic illnesses, for crises, for relapses, for regressions - increasingly specialized services that use progressively newer techniques, do not improve long-term outcomes. In other words, Killaspy concludes, I quote "better a general service that is welcoming, available, open, oriented and capable of listening, oriented toward psychosocial care, than a sophisticated, specialized service, because technicalities are the pathetic mask of impotence." Well, she is not a fierce Basaglian revolutionary, she's an Anglo-Saxon epidemiologist, but she shows that better outcomes happen where there's a service conducted with common sense, intelligence, a general service capable of, you know, navigating all 360 degrees for the demands of the population that is accessing the service, rather than seemingly more sophisticated services. Now surely there is a loss of the sense of care, which depends on the carers because they are more demotivated, because they are more tired, because they are lonelier, because they are more exposed to pressures that are simplistic pressures: "where do I put the patient?". You have to solve the problem at two o'clock in the morning in full Diagnosis and Treatment mode, the police bring you a lot of people, and the poor man who's there has to answer in a way far from an idea of care, but very close to a corporate idea of solving an unpleasant problem. And then the policy makers that are increasingly corporate, increasingly money-driven, have also changed. So we have services that struggle more and more with a little psycho-pharmacological control, a little psychological support, which is sometimes very similar to a pat on the shoulder, a lot of management, and the word says a lot, a lot of case management, that is, problem management, there is no one who takes care of anyone anymore, and the goal is always to find an immediate solution, that is, a culture of "where do I put the patient? What do I do with him/her?" becomes prevalent. So, I don't want to go back to issues that can get boring, but Diagnosis and Treatment are increasingly binding according to the data we have, CPS's (Psycho-social Centers) work less and less hours and more and more with an outpatient logic: doctor's appointment, doctor's appointment. Residential facilities are increasingly dark places

without a plan, with a lot of entertainment but without a plan of life. So these three principles that should be the situation for the acute in the hospital (who are often exposed to a situation of violence) the situation of the so-called territory, a word I hate, where it seems you are going to the dentist, that is, with a clinic that works with a logic that is not that of complete care, caring for the family and the patient, but much more rapidly clinical, and a frightening situation in the residential facilities, in the sense that they are not facilities that have any rehabilitation projects, but they have big entertainment projects - that is, they still have birthday parties with cake, the choir, the patients, patient Maria's birthday today, patient Luigi makes ashtrays out of clay, something that is very far from rehabilitation understood as reconstruction of a social contract with patients. So, let's say that there is an objective situation of regression. So, it seems to me that maybe we can change this, that maybe we could use something that has a lot to do with a mixture of ethical motivation and cultural passion, that is, I have the feeling that there are services that are very devoid of passion and very opaque with respect to ethical concerns.

Mauro Mozzani: I shall try to return to this subject. Let's say that perhaps here in Parma, and more generally in the Emilia-Romagna region, we can place ourselves at slightly higher levels than the situation you described (although it is unfortunately very true for various parts of Italy) and the work that we are trying to produce here is to connect the services that are increasingly weak - weak in numbers and in economic investment - with third sector bodies, with voluntary organizations, with community homes, etc. So, trying to maintain our gaze and direction toward paying attention to the fullness of the life of the patient. I believe, and I agree with what you said, that there is a great epistemological crisis in psychiatry: the DSM is no longer mentioned, and we now almost conceal it. We are almost ashamed of it, and it seems to me that no other DSM is currently being prepared. Evidently there is also a lack of thought with regard to biological psychiatry. Of course, giving examples such as the micro-areas, or emphasizing the need for cooperation and motivation on the part of operators, risks being something fragile, something weak, which perhaps needs broader support, which transcends the strictly technical aspect.

Benedetto Saraceno: I would like to make two or three points, which may be a little disjointed. First of all, I agree with your remark that the Emilia region is perhaps not well represented by my pessimistic and negative description, in the sense that there is a tradition of Emilian services, a tradition of an average higher quality than the national average, without offending anyone, but it is true. Apropos, Pietro Pellegrini is one of my heroes, in the sense that he is a person I have tremendous admiration for, for his work on the

health budget that is somehow a job that answers many of the questions that I am dealing with and discussing. The whole culture of the health budget is not just an administrative culture, it's a way of imagining smarter, more effective care accoutrements. Yes, I also believe that we have forgotten about the DSM 5 in Italy. Now we should clarify if we are talking only about Italian psychiatry here or a more general crisis. Because when we talk about an epistemological crisis this goes far beyond Italy, the critical reflection that we have today on the DSM began with Thomas Insel, former director of the National Institute of Mental Health in the United States who initially said "I guess maybe this stuff doesn't make much sense", so there is currently a reflection on the fragility of psychiatry that goes beyond Italy, and then I would also like to clarify this for the people who are listening to us, that I am not a connoisseur of the details of Italian psychiatry, that is, there is also a risk that I will say nonsensical things, that I am arrogant in going into too much detail about the situation and the state of the art of Italian services. Know that I haven't lived in Italy for 29 years, so I've been living in another country for almost 29 years, that is, almost 30 years, so I can't gauge the best practices and everyday life that you have among colleagues, but if I were a psychiatrist in Milan, in Rome, in Florence, I would have that. I am a psychiatrist who does not practice psychiatry at the moment, who lives in Geneva. Now these are two elements that somehow fragilize my judgements or opinions on Italian psychiatry. However, it is certainly true that perhaps we need to call for this dialogue among epistemologies. I became fond of that expression by Anne Lovell, because for example, there is a reflection made in the Lacanian field, curiously, on the production of subjectivity and the authorization of the subject, these are reflections that actually have much stronger epistemological and cultural connections than one might suspect with the phenomenological roots of Basaglia's psychiatry. I say this simply because I have been involved in these connections recently, although I am certainly no psychoanalyst, but I have been involved in epistemological aspects of psychoanalysis as well. This is to say that I am convinced that there is a need, both in terms of training operators, and in terms of understanding reality, of understanding the cross-breeding, the cross-fertilization, that is, the mutual fertilization between different disciplines, but it is not just a question of the social worker who is responsible for giving the patient the subsidy, the psychiatrist who does the clinical work, the diagnosis and the therapy, and the psychologist who does the interventions of psychological support; I'm not talking about the cross-fertilization of disciplines, but about a much higher level, which is to try to understand how today all the reflections on, for example, neurodiversity made by the large associations, especially Anglo-Saxon ones, of users, intersect. The whole problem and the debate on mental and non-mental disability, the intersecting of the issue of rights no longer seen as a simple complaint, "In that hospital they do bad things, we will press charges against them", but

today how many psychiatrists, how many operators know about the United Nations Convention on the Rights of Persons with Disabilities[2] in Italy? And they should know it by heart, it is a compass that guides the way healthcare professionals work in mental disability and physical disability in an extremely progressive way. So it seems to me that psychiatrists today don't navigate these unknown or less known seas of other cultures, those of biomedical orientation, let alone Lacanian ones; they do not even know who he is, those of psychotherapeutic-psychoanalytic orientation are often bad prescribers of a rational use of drugs, the social aspect is often translated into small interventions of economic aid to patients but without a real understanding of what it is to do social intervention for a patient, and so this cross-fertilization, I repeat this term, between different disciplines, between epistemologies, would help us a lot. You said, "but we need something that is not just a technical solicitation," yes, if a technician means something very practical, and if by solicitation we mean a cultural, moral, cognitive, important solicitation that comes from different disciplines, this I think would be very useful, very necessary. I have the impression that there is not much permeability of cultures at this time in Italian psychiatry, everyone is holding their own and there is now a defence that risks being almost a corporate defence of «We are psychologists with a psychoanalytic psychodynamic orientation. We are the psychiatrists who use medications or who use I don't know what, the residential facilities". All of these become small technologies, but which are not part of a great project and a great plan to free psychiatry from its tradition of protection that denies emancipation, that is to say in some way dominant-dominated, for a psychiatry that is closer to the culture of recovery.

Fabio Vanni: It seems that we might agree that this cross-breeding or this cross-fertilization of various perspectives is necessary. It also seems to me that perhaps we could start from words, we are in a culture of care that has made the crisis 'acuity', a human subject in need a 'sick person', the places for listening and care 'clinics', so I wonder if we could start from this. I'm very afraid that if we expect psychiatry alone to make a transformation that so radically questions its roots, we can't go much further, while I think that if we can make progress, it is due to giving space and legitimacy to other cultures. Because, of course, if we stick to a logic - which is very prevalent in healthcare, at least in our country, but I think not only - it seems difficult to me that we then expect to deal with the psychosocial and that we have the skills to understand the social determinants of disease. This is not even part of the formative culture of new psychiatrists and paediatric and

[2] https://pninclusione21-27.lavoro.gov.it/sites/default/files/2023-10/Convenzione%20ONU.pdf

adolescent neuropsychiatrists. So, I wonder if there is a need to think that mental health is not just to be dealt with by psychiatrists, or even Mental Health Services, but that it is a community issue. Of course it is a term that needs to be redefined, but I am referring here to a community of an at least broader professional nature than psychiatry. I am also addressing the issue of the public-private relationship here. In any case, I believe that the prevailing idea is that of a public service which has the capacity to intervene in people's mental problems, which it somehow ignores and fails to keep in a network of equal and dignified collaboration, a whole world of healthcare professionals, both private and social private, could lend a more authoritative hand in this. It's kind of like saying, «I can't do it, but I won't use you, or if I use you, I use you within my logic.» Among other things, there are constitutional rules in Italy which would invite us to consider the aspects of horizontal and vertical subsidiarity as a fundamental dimension of the issue of care. So, I wonder if there is a need for a major difference because I actually found your description of how services work very much in line with the reality I know. So, I wanted to reassure you that your time away for 29 years does not seem to me to have distanced you from understanding our country. I generally found myself very much in what you said, but then, we really have to make a transition: if Basaglia did not put mental illness in parentheses, but thought he had to deal with, as you say, the sick, I say of the subject, could this be a path that unites different disciplinary and epistemological perspectives, giving the word subject a meaning of social subject, of person inside a micro and macro community?

Benedetto Saraceno: You touch on enormous themes and overestimate my ability to say sensible and intelligent things. So, I'll try to say things that perhaps are not at the level of complexity of the questions you raise, but firstly, I certainly believe that today we need to reconsider the meeting between the person providing the care and the person receiving it, that is, between a supposedly knowing subject, or in any case a subject that is institutionally supposed to provide care, and a subject undergoing treatment. I think one of the vaccinations to prevent this meeting from becoming toxic is the guarantee of the presence of a third party. By 'third party' I don't mean that there is a third person in the room, but the third party understood as the context of the community, that is, the community as a place where the trivial lives of people, the experiences of self-care, of affections, desires and social roles intersect. This is the presence of this banality of everyday life within the encounter between the treatment provider-person needing treatment. It is a strong guarantee that this meeting does not self-isolate from a daily unreality but remains in daily reality. This presence of a third party, the community, you said a professional community, this too, but not only. We have to understand what we mean by professional; it can also be a cooperative community

in the area that makes wine, or the parish priest's cooperative that organizes football games, or the Union that organizes whatever, in other words, a community, understood as all those community and social bodies whose presence in the treatment provider-person needing treatment encounter. It is an enrichment and a guarantee that this meeting will not take place somewhere too separate, too, as it were, isolated from reality. What I call the presence of a third party, then anyone can give a name to this third party. Third party can be a community of other professionals, it can be a community of other subjects, it can be a community made by the community, it can be a community of peers, for example, users themselves, which we always talk little about because in Italy we talk a lot about families but very little about users in terms of empowering them. The second problem is perhaps also opening up a serious discussion about this word "care", because if the word therapy somehow does not satisfy us or does not fully satisfy us, the idea of care is certainly a broader idea. But even here, it's a polysemic term that is a little overused. I recommend reading feminist literature in order to understand what care is. There are texts by Martha Nussbaum, for example, or Joan Tronto, who are great feminist leaders, American feminist philosophers who somehow explain from a feminine and feminist point of view what is meant by care, which is a strange, mysterious and magical potion where public and private meet. Not public and private in the sense of public and private institutions, but the private dimension of the intimacy of care, in fact often it is the family who take care, care as a combination of gestures of intimacy, kindness, acceptance, of respect that is carried out on the body or mind of the person who is vulnerable and fragile at that time. But this very private intimacy is constantly intertwined with the idea that care is being provided, not out of pity, but by right, and therefore intersects with institutional dimensions where there are operators who have knowledge, so there's an operator who has knowledge and then there's knowledge from the family member's experience, and care is the very complex result of this interaction between different dimensions. I think there's a lot of talk about care, but little or no thought is given to what we mean by the term care. Finally, regarding the public-private issue that you raise, this time public-private not in the sense of intimacy versus professional, family versus other, but in the institutional sense of public, public service, and private, that is, the private professional who lives in your home, or the NGO or the cooperative that provides services to the public. But I believe that public service is destined to end; we have to believe otherwise; it's all well and good that we defend it as a moral point, and I will defend it to the death, but it is a lost battle. The public service in Italy is becoming more private every day. So, if there is a concern that a public patient cannot benefit from healthcare services that come from the private culture, it is not a concern; there will be far too many private services. I am convinced that in ten years' time only very poor people will be using the pub-

lic health service. People who have minimum economic resources will be using the private services that are affiliated with it. Also, because then this whole world of social private…., forty years ago social private was private that was in some way social, that is, ethical. Today, what is called social private is a strongly business-oriented private; that is, in Lombardy, private social services provide on-demand night shift workers to cover shifts in nighttime Psychiatric Services. So, the public pays these private individuals, they pay them ten times more than the public professionals, so those who work 38 hours a week in public service earn in a month what these on demand workers do in three nights in Milan. I am convinced that private will be the master and that then there will be a cynical private, there will be a competent private, there will be a less competent private, it will be a market, it will be a free market where you buy services. Then you will buy the services of a good psychotherapist or the services of a not so good psychotherapist, you will buy on-call doctors, you will buy services, you will buy a lot of rehabilitation and then give them playdough and clay for activities and so on because the private is winning over the public. Perhaps you Emilians do not realize this because you are still in a region that deserves credit, and that must be honoured, but I say this with seriousness and with great respect, because for you the public service is still something sacred, in short, it is fighting for itself; but look, it is not like this in most parts of the country, in most parts of the country the private service is dominant. Among other things, at present the Lombardy Region spends more cofinancing private hospital facilities and private services than it spends on the public, so this concern of an injection of private into the public sector has no reason to exist. The problem will be in guaranteeing the quality of this injection, that is, it should not be a deadly injection, but a good injection, a vitamin shot, but institutionally it's a lost battle for people like me, who are old, who thought that the universal service of Law 833 was something sacred and iconic. Well, it's a lost battle.

Fabio Vanni: I completely agree with you on this prediction. But my concern was not whether the private enters or not, I have a problem with accessibility and therefore fairness and therefore actually the fact that this brings a whole series of problems for those who cannot afford to choose. What I wonder is whether it would be conceivable for the public to recover a function of government and not simply of procurement, of real coordination, and not simply of being a provider of services that are in competition with the private sector, it seems to me that there is not even a great deal of thought about this in Emilia Romagna, nor perhaps elsewhere.

Benedetto Saraceno: Yes, I can only agree with you, I have nothing to add, it is so, it is indeed so, but at the moment it seems optimistic to think

that the public has a capacity for government, the public has a capacity for nothing at the moment. It does not govern anything, or it governs poorly, in the opposite sense of good governance, and therefore in my opinion this flow of human and cultural resources from the private sector to the public sector will be unstoppable and of course it will be a flow that contains all sorts: it will contain parts that are qualitatively interesting and parts that are qualitatively very poor. In short, I believe that today, even this private social sector, which fifty years ago was what the user cooperative was doing, which was a good thing, was considered a positive moment in which a private culture, that of the cooperative, provided intelligent and useful weapons to the culture of the public sector. I think that today it is a bit of an illusion and I think that much of this private social sector is quite different; I am perhaps skewed by the fact that being of Milanese origin and maintaining friendships and relations more in Lombardy than in other Italian regions, I'm aware of real money-trafficking situations, which means there are cooperatives that are just places where you recruit unhappy public doctors, disgruntled public psychologists, social workers and slowly also nurses who are resold in agreement to regional authorities and there is a transaction that is purely economic and financial to the detriment of the public, who then disgraced, is like the Japanese who believed that the second World War was not yet over and remained in the trenches. It will be interesting to see who will be the last psychiatrist in Lombardy who will continue to fight to work in a public service rather than as a freelancer on demand, but these are more, as it were, low-policy considerations that I do not want to dwell on.

Fabio Vanni: I believe that now, before giving the floor my colleagues who are present in the room and who can start to think about any questions they may have, I would like to point out to you that there are in fact also some private social realities which have, which are trying to have, a perspective that is attentive to ethical aspects. There is, for example, a social psychotherapy network that includes thousands of professionals who try to work in a careful way, not only of course on the economic side because otherwise you cannot survive, but also on the quality of what is done, on the collaboration with the public service, etc. But of course, I realize that the whole system proposes a deterioration at all levels and therefore also in this area, which should be an emblem of ethics.

Lelio Pallini:[3] Hello. I am the President of the Progetto Itaca Parma

[3] Lelio Pallini, President of the Association Progetto Itaca Parma ODV [voluntary organization].

Association. I wanted to refer to a point that was just touched on by Professor Saraceno, but which I consider very important, that is, the question is this: what is being done at an educational level, at the level of university courses, to guide psychiatric specialization courses to the concepts and guidelines that Professor Saraceno has outlined? I make a confession, sometimes I have wondered whether medical school is the right place for a psychiatry specialization, and perhaps it would be better to devise an independent faculty, which is neither medicine nor psychology, nor anything else. It's a strange idea that came to me, but there may be something useful in that, thank you.

Benedetto Saraceno: I would like to respond immediately because I am very much stimulated by your reflection. Well, I like the idea of a "mental health faculty", where you teach psychiatry, psychology and so on, but you call it the Mental Health Faculty, but that's just my consideration, mostly a dream. There is a very, very deep-rooted Italian tradition whose motivations have never been well analysed, and I would not be able to provide a particularly intelligent or competent analysis of this today, but in Italy, the great innovation in psychiatry has been made by the hospital world, and not academia, and I don't just think of Basaglia going to an asylum in Gorizia, in Trieste, in Parma, but I also think of all the most interesting experiences in Italy in Arezzo, Perugia, Ferrara, and I am thinking of the good quality services that were set up in Parma, Bologna, Piacenza at the time of Mistura, in Reggio Emilia at the time of Asioli. The tradition of good quality psychiatry is a non-academic tradition, rare are the Italian medical faculties that have put together the training of their students - medical students trained in psychiatry and psychiatry residents - who have put together academia and service innovation. Michele Tansella did it in Verona when he was alive, and today Verona continues to be a particularly lively and interesting location, but, let's remember, that all the psychiatry professors in the medical faculties of our country, where not part of the innovation and the reform.

Innovative thoughts came from hospitals, from the practice in hospitals. Even the innovative theoretical thoughts in interesting and intelligent bibliographies of the last thirty years of Italian psychiatry, you will find little in the field of reflection that we are doing today that comes from the world of university academia. Ninety-nine per cent came from the world of reflection of hospital workers or private professionals, psychoanalysts, psychotherapists, who wrote about it. So certainly, to your question of whether the university world today is fit and capable of training for the concepts and things that we are talking about this evening, the answer is that it never was and will continue not to be. Then this idea of imagining that there is a faculty that combines these skills and is different, and not

medical, is an interesting hypothesis that I think should be explored, I cannot weigh in on this issue, however, it is certainly true that innovative Italian psychiatric thought is not university-based.

Fabio Vanni: It is a beautiful utopia, and I find it a very interesting topic, because it is clear that if we continue to carry out training like the one we have at present, we can hardly expect innovation like the one Professor Saraceno has mentioned.

Marco Ingrosso[4]: I believe that we are in an era in which, in any case, space has been opened up, before thought and in part also action, after the pandemic, this cathartic event which certainly stirred the waters. At the moment, the pandemic seems to be absorbed by other, even more catastrophic events, but these also pose problems for us, that is to say, we are in a world that is out of control for various respects and that needs to be restructured and rethought. So, I wonder if it is possible to fit into this fissure, into this wound of our world, with the themes that have been touched upon but that must be discussed together, in my opinion. The theme of care, where the new idea in my opinion is that care cannot be carried out only by individual professions, but you must address the complexity of an individual, be it mental health, be it physical health, be it health tout court. You have to face it with a set of visions, with a set of ways in which you can bring together different competences, confront them, try to generate a new thought, so I see care that is veering toward complexity and collaboration at the same time, it is transdisciplinary, so to speak. Then there is the issue of community, which has been touched upon, and rightly so. Of course, we are starting from a kind of desert of difficulties, of very strong individualization, but I also believe that, on the one hand, the situation in Italy is different and specific in the various settings, and that the situation in the United States, for example, which has been mentioned, is not the same. I believe that there are still frameworks in the Italian situation, as the presence of the not-for-profit sector in Italy shows, but in any case, we can act under different plans to try to restructure and rebuild through the local institutions involved, for example, in the new Community Facilities. The charity sector can also be redirected toward a neighbourhood dimension, toward a dimension of everyday life. So, I liked the idea that Saraceno proposed of the community as a third party, as a third presence that, enters daily life, doing things that perhaps are needed in a micro way, but it is present with a different view on situ-

[4] Marco Ingrosso, sociologist of health and care, former full professor at the University of Ferrara.

ations. Then there is the theme of health that until now has been considered less, thinking about health not simply as individual risk, but health as reconstruction and regeneration of collective environments. Today there is also the theme, within health actually, of climate, but more generally of living beings, of complexity, ecology, One Health, so there too there is something to talk about. So by acting on this three-pronged path of complex and collaborative care and community, which is trying to rebuild through the presence of new attempts to work on various micro aspects of the situation, and health as regeneration of social well-being and attention to the new ecological dimensions of the city; I believe that by acting on these three paths together, something can be opened up, something can be thought of in order to rebuild. It is an attempt, and I believe that, for example, these new perspectives regarding Community Facilities, if they go in this direction, they open up, if instead they remain only as medical centres, then we are still in a regressive situation that will not open up new spaces. I don't know what you think about this...

Benedetto Saraceno: I agree with everything you have said, I am very much in tune not only with the things you say, but with the language you use, with the references, how to say, the words you use; they are in tune, so I do not know, I can only applaud what you say, with just one additional reflection, that you speak of care, community and health, I like this tripod, care with all the necessary reflection in order to question today what we mean by care, and I reiterate my recommendation for careful reading of the notion of care from more cultured Anglo-Saxon feminism. The idea of community, that is, the idea not only of the community as a third party, but also a re-interpretation of what community is, that is, the difference between geographic and virtual communities, and then this idea of health, which is an old WHO idea, that is, health is not just the absence of disease to say something very obvious and well-known. However, I would add to this tripod, to this stool with three legs, a fourth dimension, which is that of rights. I think that today more than fifty years ago, the notion of rights has become strained in the culture of what health is, what medicine is, what therapy is, what a hospital is. I'm not just talking about psychiatry; I'm talking about medicine in general. In other words, the culture of rights has become a predominant element in many of these debates and, I repeat, I recommend that everyone read the United Nations Convention on Disability ratified by Italy, where ratified means signed, means that a country says "I agree", ratified means that a parliament adopts that convention that becomes a law for Italy, so the United Nations Convention on the Rights of Persons with Disabilities is a law in Italy. Now, why do I recommend that you read it carefully, because it is interesting, it is a text that has not been written by the usual suspects, that is, it is a text that does not arise

from the culture of psychiatry, not even a progressive, innovative, democratic psychiatry, no, it is a text that arises from the curious interaction between legal cultures that have strongly influenced the drafting of the convention, and users. Users in this case, contrary to what happens often in Italy where the users are simply actors of politically correct screenplays - that is, you go to a congress and there is always a user that anything he/she says is applauded enthusiastically so we solved the problem of users, but when it comes to user power, it's a whole different matter. Well, in the case of the drafting of the convention, the user associations have had power, they have had power, and they have written, they have challenged, they have changed the articles, and still today, in the various institutions that govern the application and implementation of this convention, user associations are vigilant vigilantes. It's very interesting because the language in which it is written is a language that is not ours. Ours, even if we put all the most innovative and open psychiatrists you can imagine into it, it's still a different thing, it's a different culture, all new. Well, those articles, Article 12, 15, 19, they are the articles closest to mental health issues, they are very, very innovative, very transformative, they are globally accepted because they are ratified by 194 members of the United Nations. There are two countries that never ratify international conventions by political decision, which are the United States and Israel, but with these two countries, it's not because of the specific content of this convention, but because they say that conventions can force them to change national laws that are sacred, while those who accept international conventions say, "these conventions are the result of an international consensus and we therefore accept that they enter national legislation, even with the power to amend it." Well, read them, they are important, one because progressively and increasingly it will happen that doctors, psychiatrists, services, and administrators will be sued in international courts by someone who wants to start suing someone else. There are already the first cases of hospitals cited to be sued by user associations. So, there will still be an evolution in the implementation of this convention, but I recommend reading it because I think it adds to the tripod of the person speaking before me, that tripod that I really like, care, community and health. It adds this fourth element, which is that of rights, which at the moment, apart from rhetoric on human rights, is represented in a very specific, technical, operational and practical way by the text of that convention that concerns us, which concerns you very closely.

Fabio Vanni: Thank you. That seems to me to be an appropriate point. I would like to add one final point that I take home from this meeting, namely that we might need to find a new utopia that gathers the four points that you have mentioned together. I feel the strength and value that Law

180 has had for many years in mental health, but it seems to me that today, perhaps, it requires that we imagine a somewhat innovative horizon. From this point of view, I think we must prioritize children and adolescents because it seems to me that if there is anyone we should take particular care of, from this point of view, it is this target population, to use an economic term. Even if we do not take what emerges from the current literature literally, the difficult conditions of childhood and adolescence, certainly accentuated by the pandemic, but undoubtedly present well before then, are particularly worrying. Since this is, without rhetoric, our future, I think that this deserves special attention. Why do I say this? Because in the budgets of the mental health departments in our country, the number of resources allocated to the childhood-adolescence area rarely exceeds 20-25% of the budget, which means most of the spending is spent on adults. This is an element of inattention and a lack of foresight which I think is very serious.

Benedetto Saraceno: If I may make a very final comment on this last consideration, when I headed the World Health Organization's Department of Mental Health and Substance Abuse for 15 years, I had fifty officials on my staff. There were fifty people of twenty-four different nationalities, from Russians to Malays to Brazilians, they were part of my small army. The salary made available by the WHO for a role of a child neuropsychiatrist was one, that is, of fifty workers one had knowledge of mental health in childhood and adolescence. Since the age pyramids in the countries that the World Health Organisation is primarily concerned with - because the World Health Organisation does not advise the German, English, American and Italian governments, but it does advise those of Mozambique and Yemen, of Sri Lanka and Honduras - and the age pyramids in those countries are highly unbalanced pyramids in favour of children and adolescents. This total distraction is serious and this lack of interest in the mental health of children and adolescents, we find it in all countries, and we also find it, as you rightly state, in Italy. I am convinced that what you say is very important and I believe that today most of the mental health of children and adolescents is dealt with by paediatricians rather than us psychiatrists, and or by schools, teachers, or even the school psychologist, but in short, of figures who are not the public figures of the health system. I believe that your appeal is indeed an important one, in the sense that not only has the Covid issue shown us the discomfort of young people, but also, in Italy, the population of troubled young people and adolescents is now increasing. Juvenile sui-

cides are on the increase, but not only are human resources increasing to meet these needs, but also culture, in the sense that there is no great emphasis in speciality schools etc., on education for Child and Adolescence Mental Health, which I think, I believe, is crucial.

Fabio Vanni: If there are no other comments and considerations, I really would like to thank Professor Saraceno and, of course, Mauro Mozzani and the guests present. I believe that we have managed to take stock of the situation a little. It is certainly not very comforting, we did put into practice worrying words, but perhaps a few seeds of chance and hope were also sown. Thank you so much!

Benedetto Saraceno: Thank you and thanks for having me.

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