

The OPIS of Lecce: Reconstruction of its history and analysis of its organizational model Part One

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This work¹ arises inside of the debate about mental health treatment, and is intended to preserve the historical memory of the experience of the Interprovincial Psychiatric Hospital of Salento di Lecce (OPIS), reconstructing the cultural and organizational models that characterized it. In this first part we will delineate the cultural-historical context which resulted in the creation of the asylum, and its development as a psychiatric hospital; in the second part we will deal with a comparison between the results of this work and the findings on the Local Culture of Italian mental health services. The comparison will focus in particular on the results of the study carried out on behalf of the Ministry of Health from 2007 to 2009 by the Clinical Psychology Chair of the Psychology Department at the University of Rome "Sapienza," a study intended to outline the Local Culture of the CSM (Centers for Mental Health); it will also focus on the results of the same department's study, in this case commissioned by the Regional Coordinators of the SPDC of Lazio, aimed at outlining the Local Culture of the SPDC (Psychiatric Diagnosis and Care Service) of the Region.

We believe that this work is in line with the need for greater understanding of aspects of the organizational functioning of mental health services, a need expressed by many social groups, by the scientific community, and in particular by the Ministry, which for the first time has invested in research on organizational effectiveness rather than on the effectiveness of pharmacological treatments-- all of which underscore the value and importance attributed to the organizational and cultural aspects of the operations of mental health treatment services, and testify to the need for critical reflection on this topic.

The realization of this work has been difficult due to issues with sources: the archive of the OPIS has been inaccessible for some time, neglected and set aside in a basement. We therefore have made use of (in addition to the cited bibliography), the information available through the State Archive of Lecce, along with interviews of key figures among the personnel in service before 1978. These valuable interviews have allowed use to reconstruct the experience of the 1970s (beginning in 1973), and to better understand the organization of the structure and the relationship among medical personnel, and between medical personnel and patients.

Thirty years after the promulgation of Law 180/78, which called for the closure of mental institutions, the debate over that law has remained very current, both inside the professional community, and in the broader public opinion². In the current scientific debate many questions have arisen relative to the changes introduced by the law, and positions have been taken both idealizing and devaluing mental institutions. In some cases, the idealization is sufficient to evoke their reopening, as a means of control and of protecting the public from danger.

Our study intends to present a reading tied as closely as possible to historical experience, in opposition with the mythmaking (idealization/devaluation) currently taken place. In our hypothesis the possibility of developing the current system of treatment of mental health is linked to the critical reading of past experience, in the light of the history of recent years. We, along with Carli (2009) believe that today, problems related to mental illness once again are placing the organizations responsible for dealing with it at a crossroads: reassert control, or invest in knowledge? Knowledge

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¹ A portion of this work comes from the thesis on Organizational Psychology defended in July by Dr. De Pascalis as part of the degree in Sciences and Psychological Techniques at the University of the Salento.

² An expression of this interest can be observed in the statistical study on the state of psychiatric assistance in Italy, carried out in May 2003, in which a sample selected by the Doxa was interviewed by telephone. On this, see <http://www.doxa.it/italiano/nuoveindagini/salutementale.pdf>

requires understanding of the social question of mental illness; the alternative is a collusive response to a mandate which one again demands control and expulsion of diversity.

In view of this we consider it particularly important to focus on a phenomenon entirely based on *control* and on the *obligatory demand*, to analyze the salient aspects of the culture which produced it, and to compare it with the findings of recent studies on present-day mental health services.

At the end of the project with the CSM, a seminar-workshop was held at the University of Rome "Sapienza", organized by the head scientist, Professor Renzo Carli, and by his work group from the Department of Clinical Psychology, attended by ministry representatives, administrators and personnel from the CSM (psychologists, psychiatrists, social workers, doctors, nurses). On that occasion Professor Carli emphasized the complexity of the situation in which mental health services find themselves, connecting it with the cultural changes those services are undergoing: "my impression is that the services of mental health in Italy are in the middle of a difficult crossing, having left behind a riverbank whose basic form is now unrecognizable, and which was the site of great conflict, but not yet knowing where they are going, nor what is the nature of the riverbank toward which they are proceeding".

The origins of mental health treatment

The medical view of mental health problems developed at the end of the 18th century³. A fundamental contribution to it was provided by the Frenchman Pinel⁴, who introduced a "moral treatment" of the "alienated"⁵, who began to be considered as sick persons who should be cured. This was in antithesis to the practice of prior centuries, in which people with mental health problems were considered as criminals who should be punished and treated with repressive methods, and, until the 16th century, as demonically possessed and in need of exorcism. These people represented a threatening anomaly, a social danger which needed to be isolated from the rest of society and rendered innocuous at the cost of segregation, violence, and suspension of all their rights.

This medical understanding of mental health problems was accompanied by the spread of structures intended for mental health care. Internment and entrusting of a mental patient to a specialized doctor isolated the mentally ill person from society while at the same time calling on the collective to take responsibility for a problem internal to it.

While in most cases, insane asylums were converted from pre-existing structures (hospitals, hospices, convents), in some cases new buildings were constructed. One important model was the

³Initially the mentally ill were imprisoned in hospitals, prisons, and leper colonies. Later, beginning in the 16th century in England and in the 17th in France and Germany, structures were created exclusively intended for their keeping, where the first rudimentary treatments were applied. The dominant conviction of the era was that insanity was caused by internal physical defects, and thus it was necessary to intervene on the bodies of the mentally ill in order to return them to sanity. Extremely bizarre methods were used for this purpose: the mentally ill frequently received bloodlettings to render their blood lighter, punctures in the skin to permit the escape of rebellious spirits which inhabited them, or showers of freezing water to combat their wayward thoughts. Only at the beginning of the 19th century did medical and social progress bring significant changes in this area: it was then, in fact, that a clear distinction began to be drawn between the criminal and the mentally ill, and systems of medical care were modified to act not only on the bodies of the mentally ill, but also on their psyches. The goal was to re-educate minds in order to render people with mental health problems fit for life in society, to restore self-control and discipline.

⁴ In 1787 he began to publish works on mental illness, and became famous with a work on the treatment of disorders in adults, presented at a competition sponsored by the Société royale de médecine. This work resulted in his being assigned, in 1793, to the asylum of Bicêtre, where he carried out the historic act of freeing the inmates from the chains and filth in which they had been suffering, transforming the "lunatics" into diseased persons who were to be studied and treated (Enciclopedia Treccani).

⁵ The term "alienated" was used in that period to generically indicate people with mental health problems. In its more general sociological use, it denotes an isolation or separation of parts of an individual personality, or of an entire personality, from some aspects of the world of experience.

Panopticon⁶ (Bentham, 2002), proposed by the English philosopher and legal scholar Jeremy Bentham in 1791. We believe that these buildings were the most significant expressions of the culture which founded, in that historical period, the treatment of persons with mental health problems. The Panopticon was initially proposed as a prison. The structure of the Panopticon was composed of a central tower, in the middle of which a guard was stationed, surrounded by a circular construction which housed the cells. Having a radiocentric form, it allowed one guard to keep all of the inmates under control at all times; the inmates, on the other hand, could not know if and when they were being observed, and this was supposed to lead them to constantly preserve order and discipline. The link with a culture that criminalized those with mental health problems seems evident, as does the perfect synthesis between the structure of the building and its predominant function: the control of the mentally ill and the maintenance of discipline.

The medical view of mental health problems was consolidated in the context of positivist thought, which introduced scientific observation and the cataloging of symptoms and pathologies, interpreting such problems as *mental disorders*. This was an organicistic interpretation of the mental health problem, in which this was a sickness, with a physical etiopathogenesis. Kraepelin, with his nosographic model, refused to acknowledge any cause or consequence of sickness which was not perceptible from an organic point of view, categorically excluding psychological considerations from his study.

Insane asylums as specialized structures for the housing of the mentally ill increasingly began to spread throughout Europe, probably due to the consequences of the Industrial Revolution, with its increased possibility of social alienation. On June 30th, 1838 the French parliament approved the first European law on the insane, which supplied a judicial corpus to psychiatry and definitively transformed what had been a political and social problem into a strictly medical issue: "On the canvas of the contractual society which the French Revolution created, the insane is discordant. Being irrational, he is not subject to the law. Lacking responsibility, he cannot be the object of sanctions; incapable of work and service, he has no place in the regulated circuit of exchange. potential sources of disorder, he must be repressed more than ever, but on the basis of another criterion of punishment than that which the law sets forth for those who have voluntarily broken the law. Islands of irrationality, he must be administrated, but according to different norms from those which assign the normal subjects of a rational society to their places, and subject them to their duties." (Foucault, 1977, p. 139).

Relative to the outside world, psychiatric hospitals were closed off and isolated, located in marginal and peripheral areas of cities, so that not even the views of the "well" citizens would be disturbed. Internally they were divided in various zones according to the physical and psychic conditions of the patients, their age, and their gender. The reception area, where the mentally ill were received on arrival and remained during an observation period, was the least harsh one. Aside from that, one of the principal requirements was the separation of more manageable patients from those who showed signs of being violent or dangerous. The latter were sent into the secure zone (the *reparto degli irrequieti*), which they did not leave: indeed those who were placed in that zone lost any possibility of a future release. The zone of the peaceable chronically ill (*i cronici tranquilli*) on the other hand, housed the more compliant patients, whose acceptance of the rules and respect for the authority of hospital personnel entitled them to greater freedom and autonomy. This did not guarantee them the possibility of being released; more often these patients remained in the hospital until the end of their lives because outside the hospital there was no one who capable of assuming responsibility for them. When they became gravely ill or grew old and lost their self-sufficiency, they were transferred into the medical zone (*il reparto di infermeria*). Some psychiatric hospitals included areas for the "filthy" (*i sudici*) which took in incontinent patients and those unable to attend to their basic personal hygiene. Here, at times, instead of trying to rehabilitate the patients, the hospitals abandoned them to their own devices, relegating them to separate quarters, with a resultant decline in their hygiene and their health.

⁶ An example of a Panopticon is the "Padiglione Conolly" of the former Ospedale Psichiatrico San Niccolò in Siena (cf. Bentham, 2002, pp. 18-36).

In accordance with the social mandate created by the Law of 1904, the insane asylum was primarily a container in which to hide and control the “refuse of society.” The goal of treating and curing illness took a back seat to the primary goal of social control, and was relevant mainly in the case of patients who remained in the hospital for a short time. For the others, those who stayed there for their whole lives, the isolation from family and affection, and the violation of their privacy, tended to exacerbate their conditions.

History and organization of the OPIS of Lecce

At the end of the 19th century the need to create a Provincial asylum began to be felt keenly in the Otranto region⁷ as well. At that time, people with mental health problems were largely scattered in the countryside and in towns and villages, and often belonged to indigent families unable to bear the burden of caring for them. In addition, there was no place in the territory where the mental ill could be housed even temporarily, while an asylum in another region which could accept them was being found. The first moves of the Public Administration went in precisely this direction: in 1879 a search was initiated to locate a suitable building for this purpose. The building chosen was the *Ricovero di MendicITÀ of Lecce*⁸, an almshouse occupying in the former Convent of the Olivetani since the suppression of convents with the law of July 7th 1866. In 1882 four suitably outfitted “custody rooms” were installed in the *Ricovero*, with padded walls and restraining beds, and rules were created for those “quarters for the poor madmen” (*camere dei mentecatti poveri*) laying out all the specifics for their management⁹. Control of the structure was entrusted to a Doctor Vigneri, who found himself, with frequent difficulties, having to take in almost 200 mentally ill persons in a few years. These patients remained there for a maximum of ten days, before being sent home or transferred to real asylums which would offer them superior care. In particular the Deputazione Provinciale di Lecce had signed an agreement with the asylum of Aversa¹⁰, to which the majority of the mentally ill from the Province of Lecce were sent, in return for the payment of an established amount, and with the right to verify at any time that the patients were receiving appropriate care¹¹. The mentally ill persons sent to Aversa were required to be accompanied by adequate documentation to establish their physical and economic condition, but it appears that the doctors and mayors of Lecce were somewhat imprecise in this regard, given that in an 1876 letter of the Segretario Generale of the Aversa asylum urged them to compile fully and completely the forms and accounts of the patients¹². It was quickly realized that the four rooms of the *Ricovero* were completely insufficient to deal with the increasing number of persons needing care. Doctor Vigneri himself was the most fervent supporter of the creation of an asylum in Lecce.

In the city there was another convent available, that of the Padri Alcantarini, which after the law of 1866 had been ceded to the Province. The Convent of the Alcantarini was originally known as the Convent of San Giacomo because it was attached to the church of that name, which was later renamed for San Pasquale. It was a 17th-century building constructed on the orders of Ferrante d’Aragona outside the city walls, to which it was connected by a long, tree-lined avenue which led to the Porta San Biagio. In 1652 the convent was suppressed by the Pope and subsequently acquired by the Padri Alcantarini, a Franciscan order of Spanish origin. In the beginning of the 18th century it was enlarged, and a large part of the adjacent park was incorporated into the Convent. The Convent contained small, bare cells lit by narrow windows, which were intended to promote the prayer and meditation of the monks. The official ceding of the Convent to the Province of Lecce occurred on September 23, 1870, with the corollary that it would be used as an almshouse.

⁷ Otranto Region a historical and geographical region of Apulia. It encompassed the actual territories of Tarentum, Brundisium and Lecce. In this work, we use also the expressions: province of Otranto and Terra d’Otranto (Land of Otranto)

⁸ Archivio Di Stato Di Lecce, Foglio 120, Busta 26

⁹ *Ibidem*

¹⁰ In Campania the care of mental illness was more advanced: the asylum of Aversa had already been founded in 1813 at the orders of Gioacchino Murat and in Naples a special law for the treatment of the mentally ill, anticipating the national law, had been promulgated some time before.

¹¹ Archivio Di Stato Di Lecce, F. 151, B. 34

¹² Archivio Di Stato Di Lecce, F. 151, B. 34

However, in contravention of this clause, some portions of it were temporarily granted to the School of Agriculture until, in 1887, the former convent became a barracks, housing the 84th Infantry Regiment for ten years (Sinisi, 1994, p. 45). Meanwhile, on January 3rd, 1895, a historic session of the Provincial Council of Terra d'Otranto was held (in which Vito Fazzi, among others, took part), in which a resolution to create an insane asylum in the province of Lecce was unanimously approved. Along with this resolution the Provincial Administration required that the military vacate the Convent of the Alcantarini, so that work might begin to convert it to an asylum. The plans were prepared by the engineer Libertini, and sent to Naples for the review of the famous psychiatrist Leonardo Bianchi, who proposed some small changes:

"I declare that although Libertini's plan does not represent an ideal asylum, because of the necessity that it be developed on an older structure [...] it can, as far as can be determined from a general plan, meet all of the needs of housing and care for the mentally ill in the province of Lecce"¹³.

In addition, a budget estimate was created which suggested that, although the updating of the structure and the payment of personnel would represent a substantial investment, the expense would be only slightly higher than that which was already being spent to send the mental patients elsewhere and support them, while offering the additional advantage of finally allowing the use of a true asylum¹⁴. The plan and its budget were presented at the Provincial Council, where a vigorous debate arose between those in favor and those against; the plan was received final approval in December 1897¹⁵. The sensitivity shown on this and subsequent occasions by the local Public Administration clearly demonstrates how much ideas on the mentally ill had changed from the past, and that the provincial asylum was viewed as a solution not only to social and economic problems, but most of all to human problems. In 1900 the conversion of the Convento was completed, thanks in part to the contribution of two eminent Neapolitan psychiatrists, the aforementioned Professor Bianchi and Professor Andriani, who had provided valuable advice about the medical and technical-logistical organization of the structure. The building now had space for 200 inmates: 150 men in the original structure, divided by type (filthy, agitated, peaceable), and 50 women in a two-story wing built to the south of the convent. The management of the women's area, along with the bursary, laundry and cooking services, were entrusted to the Sisters of Charity, who occupied the buildings adjacent to the church. On the ground floor of the convent were the infirmary, the medical administration and the observation zone; the other sections were located on the second floor. The building was provided with electricity, small kitchens, and water heaters; the only deficiency was a lack of running water (the aqueduct of Lecce had not been completed), which necessitated the collection of rainwater and spring water. In general the building seemed entirely functional: its internal spaces were organized to be neither overly dispersed nor overly constrictive; it was well-lit, located in a green, not humid, and near the city but in a peaceful setting.

The imminent expiration of the contract with the asylum of Aversa created a need to begin operations at the Lecce asylum as soon as possible, and do so it was necessary select its personnel. Doctor Giovanni Libertini was elected as its first director, along with a head doctor and two assistant doctors. The first nurses were all from Naples, on account of their greater experience in the field.

The birth of the asylum in Terra d'Otranto

The *Provincial Asylum of Terra d'Otranto* officially began operations in March 1901. After a few years, in response to a rapid increase of patients admitted, its staff was enlarged and planning began for the construction of new wings. This increase in the number of patients was however contained by an admission system which prevented abuses: to be admitted to the Lecce asylum it was necessary to present many documents, among which the certifications of the patient's economic situation, declarations of witnesses on his insanity, and an exhaustive form filled out by

¹³ Archivio Di Stato Di Lecce, F. 147, B. 33

¹⁴ *Ibidem*

¹⁵ Archivio Di Stato Di Lecce, F. 147, B. 33

the doctor describing in detail the physical and mental state of the patient, his family of origin, his tendencies, and any treatment already administered.

The inmates were held in good conditions, at least to the extent possible given the knowledge and treatment methods of time, but in 1905 several newspapers publicized accusations against the managers of the institute, asserting that the patients were not being treated appropriately and that food was scarce but expensive; a commission of inquiry was created which determined the accusations to be unfounded, found that the food provided to the patients was sufficient and of good quality, although purchased inexpensively, and also that the personnel of the asylum tolerated the agitated behavior of the inmates without reacting to it¹⁶.

In 1901 the provincial asylum already possessed internal regulations setting out roles and duties¹⁷; this was substituted in 1907 by a more organic set of norms, inspired by the national law promulgated in 1904¹⁸. The law of 1904 conferred on insane asylums the mandate of protecting society from the dangers of the mentally ill, by means of their exclusion and isolation from the community.

The regulations specified very precisely the operations of the asylum, its organizational chart, employee duties, hours of service and days off: an doctor had to be present in the institution at all times, along with a head nurse in charge of the men's section and a prefect nun assigned to the women's wing; these were assigned to keep track of their subordinates. The nurses, whose preferred age range was also specified, so that they might be young and vigorous (for women being single was an advantage), had to live in the building and had to "tolerate patiently the abuses of the patients, limiting themselves to acts of self-defense in response to their violence. They were not permitted to use coercive measure on the patients without a doctor's approval." (Sinisi, *op. cit.* p. 65).

The goals of the asylum structure emerge clearly from the regulations: control, vigilance, and, when necessary, coercion. These aspects can be linked to various cultural nuclei. On the one hand there is the idea of the mentally ill person as a danger to himself and others, and as in need of internment. As we have said, this idea was at the heart of the law of 1904. Along with this we find aspects linked to the vision of the work of the asylum personnel, as a social mission to be pursued with total dedication and self-sacrifice. The lodging of nurses in the asylum, the idea that female staff should not have their own families, along with the substantial role of nuns reinforces the idea that work in this environment was a mission, a true vocation. Finally, aspects emerge connected to the medicalization of the problem, as can be seen in the use of doctors, nurses and pharmaceutical treatments, although these last seem more intended for the maintenance of control than for therapy. It is worth remembering that self-sacrifice, as something of inherent value, did not imply checks on its operations. The entire organization was founded on the obligatory question which annulled organizational function. There was no product, no agreed-on outcome; only the fulfilling of prescribed norms for the maintenance of control. These aspects, as we will see, will

¹⁶ Archivio Di Stato Di Lecce, F. 655, B. 109

¹⁷ Archivio Di Stato Di Lecce, 3° Deposito, F. 2699, B. 502

¹⁸. In Italy the first law regulating insane asylums was promulgated in 1904, and it remained in force for more than 70 years. This law, called the "Legge Giolitti" after the Interior Minister of that era, took up most of the suggestions of the French legislation, sharing with it the fundamental idea of the mentally ill person as requiring confinement because of the danger he poses to himself and others. The law provided that admission to these structures would happen "only" involuntarily, and by means of a procedure controlled by law enforcement and the judiciary. The care of the mental ill fell under the authority of the Interior Minister. The law of 1904 decided on the commission of the presumed "lunatic" according to the criteria of danger to self and others, along with public scandal, contributing in this way to the reinforcement of a negative idea of mental illness. Evidently the law was focused on public order rather than on health. Furthermore, the bases on which the confinement of subjects was determined were very arbitrary, and as a result many families, especially poorer ones, forced the issue somewhat to obtain a medical certificate permitting them to commit a relative who was not dangerous at all. In this way the families lightened their economic burden, given that the support of indigent patients (the majority) was the responsibility of the province. An aspect of this law was to establish the creation of insane asylums in every province, to allow inmates to be nearer to their families. This element had among other things the goal of maintaining order and public safety throughout the nation. This law, and the individual regulations which every asylum established on the basis of the national law, transformed asylums into true detention centers, whose directors had great power: their opinions were decisive in determining the definitive internment or release of patients based on their conduct.

remain throughout history and to a certain extent will characterize the first phase of the DSM (Paniccia, Di Ninni & Cavalieri, 2006).

At the beginning of the 20th century the staff of the asylum were subject to very rigid rules, frequent checks, onerous work schedules, and disciplinary proceedings when found to have been negligent, especially when this negligence resulted in the escape or death of a patient. The culture was founded on work at the limits of possibility; the climate was one of volunteerism and self-sacrifice. Better work conditions, with increased benefits and days off, were not introduced until years later. In those years the staff was enlarged to include a gardener to tend the grounds and the garden, not only to furnish the asylum with homegrown food and to sell the excess, but also to provide work for inmates selected by the director for the benefit of their health; the inmates would also be monetarily compensated for their labor¹⁹. In this initiative can be seen the beginnings of the occupational therapy which would later be employed.

With the arrival of fascism the Province of Terra d'Otranto was divided in three different provinces: the Province of the Jonio, the Province of Lecce and the Province of Brundisium; this resulted in the division of their state assets. It was decided that the asylum would be held in common and managed consortially by the three Provinces, who would be required, to contribute to its expenses in proportion to the number of patients from each province. In 1930 an Administrative Counsel, composed of representatives of all three provinces, was nominated to manage what was now the "Consortial Asylum of the Salentine" (*Manicomio Consortile Salentino*). In the meantime the asylum continued its expansion: work had begun on the enlargement of the men's wing, the construction of a separate women's wing, a perimeter wall and a woodshed.

The institution of the Interprovincial Psychiatric Hospital of Salento

1931 saw the creation of the OPIS (Ospedale Psichiatrico Interprovinciale Salentino, the *Interprovincial Psychiatric Hospital of Salento*), a hospital consortium of the provinces of Lecce, Brundisium and Tarentum, with both medical and administrative autonomy. The structure began to depart, in its name and also in its methods, from the old idea of an asylum with all of the negative associations this carried, although it took time to break all of the links with the recent past. During the 1930s, due to the interprovincial functions which the OPIS carried out, there was a dramatic increase in the number of inmates (which reached 865 in 1938), resulting in management difficulties due lack of means, space and equipment. The prestige and reputation of the Hospital continued to grow, but beds grew scarce, many patients were installed provisionally in corridors, and the staff were increasingly insufficient, at times negligent, and tested by brutal work schedules. The director at that time, Professor Gullotta, tried to respond to the urgent situation by asking for intervention on the part of the administration. His most frequent requests were to modify the regulations in accordance with current demands, increase the staff and improve its training, make residence in Lecce obligatory for employees and prohibit them from taking on other work. The culture seems to tend ever more toward viewing work at the OPIS as a vocation to be lived with total dedication. Professor Gullotta strictly observed the personnel to prevent errors to the extent possible, but overcrowding resulted in continued increases in fights and injuries, and a split began to develop between the technical direction of the hospital and its administration, with the latter seeming somewhat unresponsive to the requests of the former (Sinisi, 1994).

In 1939, following the transfer of Professor Gullotta, the director's role was entrusted to Professor Umberto De Giacomo, who held the post for a long time, and with great dedication and commitment reformed the hospital, transforming it into a model of efficiency. De Giacomo was a dynamic doctor, attentive to the changes of the time and to scientific progress, and convinced that mental hospitals, more than other health institutions, needed to adjust to new social sensibilities. The first problem that he had to confront was overpopulation: the patients were so great in number that they were sleeping right next to each other and had to take turns in the dining hall and the bathroom: this resulted in an increase in conflicts, and in the use of coercive measures to control them.

¹⁹ Archivio Di Stato Di Lecce, F. 260, B. 60

First of all a careful study of the patients was undertaken, separating those who could be immediately dismissed from those who definitely needed to be retained. In addition, a careful selection process was introduced at the time of admission, redirecting some patients toward other entities more appropriate for their pathologies. After only a month the number of patients had noticeably diminished.

Under Dr. De Giacomo and his team (which included Dr. Vito De Pascalis), the OPIS adopted the most innovative treatment systems of its era, many of which sought to provoke a shock in the patient to obtain, via a strong disturbance, a leveling and normalization of cerebral function. The methods most used to cause the shock were the injection of fever-producing substances, IVs of cardiazol to cause convulsions, and insulin therapy, which caused comas of varying depth. After Cerletti's discovery the creation of shock from electric current became common, and this type of therapy, adopted in the OPIS as well, soon revealed itself to be more effective, less expensive and less hazardous to the patient's health than insulin shock.

In 1939, of 140 patients treated with electroshock therapy, 40 were declared cured, 50 showed significant improvement and the other 50 remained in the same condition. Compared with prior systems these results were decidedly encouraging. Other treatment methods adopted in those years were malariotherapy, intravenous or intravertebral injections, and the administration of sedatives, tonics, vitamins, calcium and hormones.

The same year, also in accordance with De Giacomo's wishes, a new division of patients was introduced, based on gender, financial resources and type of problem (more or less threatening to order and community life inside the hospital). The hospital structure was thus subdivided: just after the entry gate, to three right of the tree-lined avenue, there was a one-story wing, called "Villa Salento" in which were housed the pensioned patients from wealthier families; ahead on the left the three men's wings (the first of which consisted of the buildings of the former convent) and on the right the two women's buildings. Behind the second women's building was the isolation building, later called the infirmary building. In the first two buildings (male and female) were housed the patients under observation and in intensive care (in particular epileptics and *restlesses* were placed in the second building) while agricultural workers and artisans were housed in the third men's building (Sinisi, 1994).

Another significant reform instituted by the new director was a drastic reduction in the use of coercive measures: agitated patients no longer needed to be shut in isolation cells, the use of straitjackets was abolished, and it was decided that the only restrictive measures for continued use were sedative injections and handcuffs for patients confined to bed. In addition, in an attempt to ensure that the use of these systems would be moderate and reasonable, appropriate documentation procedures were established.

These changes were made possible in part by the introduction of new anticonvulsive drugs into patient therapy. In fact, following an experiment on a group of epileptic patients conducted by Dr. Vito De Pascalis, assistant doctor to Dr. De Giacomo, the use of Luminonal was abandoned in favor of Dintoina, which at equal dosage proved to be more effective in reducing the frequency of, and in some cases entirely preventing, convulsions²⁰.

In this phase of the OPIS's history, the use of occupational therapy established itself more firmly, although it seems to have been based mainly on the convictions of one doctor, and to have been motivated neither by scientific hypotheses nor by precise therapeutic goals, as much as by common sense and the idea that activity could be beneficial. Indeed, De Giacomo, entirely convinced that inactivity was harmful to patients' health, and that exercise and open air were definitely useful, increased the use of occupational therapy, trying it with 22% of patients: some of these were assigned to agricultural labor, some to the laundry and some to the kitchens. Equipment for sewing, weaving, embroidery and cobbling was placed in the women's buildings, and a group of inmates was assigned the task of helping the personnel keep the facility clean and orderly.

Although the chronic shortage of personnel had been mitigated only partly by the hiring of new assistant doctors, De Giacomo did what he could to improve the preparation of his staff, organizing training courses with himself as instructor, which were open both to employees and outsiders. The director also dedicated himself to supplying the OPIS with diagnostic equipment: the hospital was

²⁰ Archivio Di Stato Di Lecce, F. 260, B. 60.

lacking the necessary supplies even for basic analyses like urinalysis, and there was no possibility of performing radiological tests to determine the presence of tuberculosis or analysis a variety of injuries. The most significant problem was finding the space for these new functions; ultimately it was decided to carry them out in two rooms near the director's office. Thus, in the structures around the church and the former convent, a new nucleus of strategic activity was created, comprised of the administration, the school for nurses, the diagnostic and radiological labs, and the library, which the director took it on himself to organize and update.

Another area in which De Giacomo exerted his efforts was the extension of the OPIS's work outside its walls, to allow early diagnosis and prevention of mental illnesses, and to provide continuity of treatment to patients who had been released: to this end an ambulatory clinic was created in the gatekeeper's building, in which medical exams were conducted and medicines were distributed free of charge.

In addition, an employees' club (*dopolavoro aziendale*) was created for the enrichment of the hospital's staff (this was in the midst of the fascist era), and a small theater was installed in one of the men's buildings in which plays were put on which inspired great enthusiasm (and much participation) among both employees and patients.

In the space of only a year many significant improvements had been introduced, but in 1940, with the coming of war and the beginning of a period of general indigence, the OPIS entered into a phase of poverty and decline. De Giacomo and De Pascalis were called away to the fighting.

The revival of the Postwar era: psychiatric surgery, electroshock and work therapy

Returning to the Hospital after the end of the war, De Giacomo and De Pascalis were confronted with a desperate situation: the patients were malnourished; available bedding was so scarce that it could be changed only once every 15 days, for a third of the patients; a lack of soap and fuel meant that bathing and disinfection of beds with gasoline had become impossible; parasites were flourishing; there were few medicines and few bandages, and the electroshock machine was broken. That year the mortality rate among the inmates rose to 15%, compared to around 6% before the war; this was, however, lower than that at other Italian psychiatric hospitals.

With the arrival of the Allies and thanks to the dedication of the Provincial Administration and the hospital's delegated counselor, it became gradually possible to respond to the most pressing needs: stocks of medicines were obtained from the Allied Control Commission, from pharmacists, from the military hospital and the provincial doctor; and families of subsidized patients were required to take responsibility for acquiring their medicines. The electroshock equipment was repaired and many patients underwent shock therapy, while the use of work therapy increased, incorporating 30% of the patients, who played an active role in the hospital's reconstruction, given the need to sew new sheets, stuff mattresses, knit stockings and sweaters, and disinfect the entire building. Despite the hospital's straitened circumstances, shows continued to be performed in the hospital theater: these represented the only form of recreation for inmates and staff.

In a few years conditions at the OPIS were once again excellent, with a lowered mortality rate and a dramatic increase in admissions and cures (though these developments resulted in budget difficulties)²¹. The hospital once again became a model of efficiency, to such an extent that in 1948 De Giacomo was asked by the Governing Council of the Italian Society of Psychiatry to give a talk on the treatment of schizophrenia: "A clearer sign of official recognition on the part of scholars in this science could not have been hoped for by this hospital, which was placed in front of one of the most important university clinics in Italy" (Sinisi, 1994, p. 105).

In those years a neurological department was created in Villa Salento, the number of patients grew while the percentage of recidivism fell (35-40%), and the average length of confinement was around six months. Almost half of the patients underwent convulsive treatment: this was the most commonly employed method of treatment in those years, due in part to the acquisition of a second electroshock machine. On this subject De Giacomo stated that "The most striking results were observed in melancholic and hysterical patients and in cases of acute schizophrenia, so much so

²¹ Archivio Di Stato Di Lecce, F. 2700, B. 564.

that for these disorders, not only has this type of therapy has become the preferred option, but the failure to use it promptly and systemically in these cases should be condemned, as it uselessly extends the suffering of the patient and does nothing to stop the exacerbation of the disease." (Sinisi, 1994, p. 106).

As far as other types of treatment were concerned, while work therapy continued to be used to counteract the monotony and idleness of confinement, there was a decline in the use of cardiazol for convulsive therapy, while the use of pyrotherapy, malariotherapy and insulin shock increased (the latter of these due in part to the increased availability of American drugs). New and more invasive techniques were tried, like the prefrontal lobotomy, which involved cutting of layers of cerebral tissue to reduce the motor agitation of some patients; these did not produce positive results, but offered the opportunity for a closer study of cerebral functions. De Giacomo's team also sought a reform of the antiquated law of 1904, one which would create a single body of regulations for all psychiatric hospitals, and would also provide guidance in the management of personnel.

During these years two important psychiatric conferences were held, one in Paris in 1950, the other in Taormina in 1951; in both of these De Giacomo gave talks which were received with enthusiasm, in which he described the results of psychiatric surgeries performed on patients at the OPIS. Shortly thereafter the De Giacomo era at the OPIS came to an end, as the director left the hospital to become the director of the Psychiatric Hospital of Genoa. During his years at the helm, the OPIS, although faced with countless difficulties, saw a surge of modernization, and much was done to improve the living conditions of the patients, although their great numbers and the hospital's limited resources did not always allow for sufficient care and treatment. For a short while it appeared that the OPIS might become a treatment center equal to university clinics, but a lack of funds and resources kept it from achieving this step.

After De Giacomo's departure the management of the hospital was provisionally assigned to Doctor Bozzi-Corso; in 1954, Professor Zara was nominated as new director, and he remained in this post until 1966. Zara attempted to improve the specialized training of his medical personnel, promoting professional development and participation in conferences. Further, since doctors were scarce and the hospital now housed 900 patients, he arranged to bring graduate students in psychiatry into the hospital as interns, to play a supporting role in the hospital's operations. At the end of the 1950s a deficiency was remedied which had been tolerated for some time: the hospital received radio-diagnostic equipment, which was placed under the responsibility of Doctor Quarta-Colosso, along with electroencephalography machine; in addition, the infirmary was equipped for the performance of minor surgical operations.

This meant that patients would no longer need to be transferred to other locations for care and treatment, a practice which had created logistical difficulties and involved enormous costs. (Sinisi, 1994, p. 118). In addition, new buildings for the kitchen and the laundry were constructed on the left side of the complex, behind the first men's building.

The 1960s: creation of a social work service and the birth of the first recreational initiatives

At the beginning of the 1960s the OPIS of Lecce began to take on the form which it would retain until the end of the 1970s, shortly before the arrival of the Basaglia law. During this period the psychiatric hospital of Lecce became more and more focused on treatment, and less a place of lifetime confinement for patients. Meanwhile, the psychiatric community was become increasingly aware of the need for a reform of the obsolete law of 1904, and of systems of treatment and structures for housing mental patients. A new sensibility about mental illness was developing, and this new perspective was shared by the government as well.

More and more often this branch of medicine received the attention of well-prepared doctors, who brought innovative ideas, sought out new treatment methods which would be more respectful of patients' dignity, and attempted to reduce rigidity in the organization of mental hospitals. At the same time the OPIS enjoyed the benefits of the economic boom, which increased the available resources of the hospital and thus improved the lives of the patients, along with those of the staff, who gained improved conditions in part due to the efforts of labor unions in that era.

In the 1960s the most urgent problem for the administration of the OPIS was without doubt overcrowding. The number of admissions had passed 1300, and the hospital's sanitary facilities, as well as its staff, became more and more insufficient. On the one hand recent pharmacological discoveries had made new substances available to treat mental disorders and make patients more docile, lessening their violent episodes (neuroleptics, tranquilizers, anti-depressives); but nevertheless it was necessary to increase the space available for the housing of the inmates. Thus, while the main facility was constantly under renovation, new work began to convert the structure of the former Tessilmarod di Strudà into a housing facility for 200 peaceable chronic patients. At the same time in Latiano, near the Psycho-pedagogical Medical Institute, an agricultural community was created to employ a group of 50 people, assisted by specialized agricultured workers. Outpatient prevention efforts were increased, along with outpatient treatment via the creation of nine new outpatient clinics (Sinisi, 1994)²².

Nonetheless it is important to note that while the number of admissions continued to increase, at the same time the number of releases increased as well, and the average length of confinement decreased. This indicates a change in the view of the problem of mental health, but at the same raised the question of reintegration into society.

Those years saw the growth of a social, familial and relational understanding of the problem of mental health, and the need arose to introduce local services to treat these aspects as well. For this reason 1961 saw the creation of a social assistance service. Initially the OPIS hired three social workers and their work consisted in the creating files on the patients, monitoring their treatment, performing statistical studies and conducting home visits to determine the financial and familial conditions of the patients, and if they could receive suitable care after release. Among the functions of the social workers was to deal with the reintegration into society of released patients, or, when necessary, their transferral to other entities, as well as to monitor home care.

Subsequently, in addition to these three social workers, students and interns at the high school of social work began to visit the OPIS, bringing liveliness to the hospital, improving its entire climate and lightening the labors of the nurses, who were still few in number relative to the number of patients (one nurse for every 18-20 patients). The first recreational activities began to be instituted; activities which even now are characteristic of mental health services. These initiatives were created based on work in the field and not from a hypothesis of work founded on a theory of intervention, a characteristic which often has remained to the present day.

The young students, indeed, in addition to supporting the work of the staff, took it upon themselves to entertain the patients with games, parties and social gatherings, emphasizing the human dimension of the mental health treatment and promoting the grown of human relationships among the patients. (Sinisi,1994, p. 120).

The 1970s: The valorization of human relationships and the consolidation of social and recreational initiatives.

As has been noted, to understand and analyze the experience of the OPIS in the 1970s, it was possible to supplement archival information with interviews with key witnesses who worked in the hospital in those years. We chose to interview three professional figures²³ representing three professional areas of the OPIS, a psychiatrist, a psychiatric nurse and a social-sanitary assistant. In this way it was possible to analyze the emotional dynamics underlying the relationships among the staff, and between staff and patients.

The interviews reveal noteworthy aspects of the organization of the OPIS in those years. Among those aspects are a hierarchical organization of relationships, a culture predominantly based on control, the anonymity of the patients, and at the same time the existence of a core of values which permitted the development of significant experiences of intense humanity.

²² *Ivi*, pp. 135-150

²³ We would like to thank Dr. Marcello Rollo (psychiatrist and Director of the Mental Health Center of the Asl di Lecce), Umberto Savoia (psychiatric nurse) and Fiorentino Solazzo (retired social-sanitary assisant) for their valuable assistance.

The image evoked is of an environment which "it would be more than euphemistic to describe as "alienating" (Rollo). Solazzo admitted that his first impression was very negative, and that for a short time he was afraid that he would not be able to work there.

Both Rollo and Solazzo remember being struck by the powerful stench which pervaded the hospital's rooms. Solazzo describes the building as a large structure, with beds one next to the other. The beds had railings, too which some of the patients were bound, and there were no cabinets or nightstands. Solazzo recalls that the same room housed the tables where patients ate. The toilets were next to each other without any barriers: "without even a wall separating one bathroom from the other". Rollo describes the patients by saying that they did not even seem like people: they hung about in those enormous rooms, obsolete and impersonal and lacking even a minimum of hygiene.

The structure contained two large sections for Observation: one for men, and one for women, in which non recidivist admissions were temporarily housed. Recidivist patients, on the other hand, were placed in the same section from which that had been last released. After an initial period of at most a month, the patients were placed in the six buildings in which the hospital was divided: three for women and three for men. The second building (for both men and women) was used for "dangerous" patients: it was walled in and isolated from the others.

Savoia explained that after a period in the Observation area, the patients were transferred to the appropriate buildings. "This division," he added "was not made based on type of disorder, but instead based on degree of dangerousness. The patients believed most dangerous were sent to the second building. An exception was Villa Salento, which later became Villa Libertini. This was an isolated building, and one which required payment, which housed the well-off and privileged patients. The only exception to this rigid organization was the "Villa Salento". This was a structure intended for paying patients, among whom were the middle-class of Lecce. Needless to say, the treatment there, both logicistical and medical, was distinctly superior". The OPIS also had two medical areas (one for men and one for women), a large garden at the end of the central avenue where work therapy was conducted, a stall with a goat used for medical experiments, a laundry, a kitchen, offices for internal maintenance and a cinema. There was also a soccer field and, remarkably enough, a skating rink. These facilities, however, were not intended for the patients but for the staff and their families.

Further, since the Psychiatric Hospital served the needs of the provinces of Lecce, Brundisium and Tarentum, a subsidiary hospital was established: Villa Santa Maria (where the *Città di Lecce* clinic is currently located).

Hierarchical Organization

The hospital was organized according to a pyramidal structure: at the top was the director, with the head doctors under him (one for every building), followed by doctors, supervisors, select nurses, regular nurses and assistants. Relationship among the staff, as we have already indicated, were based on a rigid hierarchy: only the supervisors could interact with the doctors, and indeed every step of the pyramid could have contact only with neighboring steps; there was no possibility of jumping over steps.

The numerical disproportion was such that in general every 150-200 patients were assigned only two doctors and four nurses, even in the case of the second building, which housed the most dangerous inmates. For security reasons, hospital regulations did not allow doctors to have personal relationships with patients, or to spend time with them. Rollo adds that the hierarchy was not merely a formal one and that relations between staff members at different levels were regulated: "The supervisor was the only person authorized to talk with doctors. Only in his absence could he be substituted by the select nurse. For other employees it was almost unheard of to address superiors except when questioned."

In the 1970s, however, the first attempts were made to counteract the dominant hierarchical structure. Rollo told us that "the generation of young psychiatrists which arrived along with me at that time began to undo this structure. I remember that one day I was called by the Director, who informed me I had been caught speaking with an assistant, and reproved me for this, reminding me that I was a doctor and that I had to maintain my position. Obviously, this was a reproof that I did not accept, and I continued to act in the same way — as did many of my colleagues."

The same change also occurred with respect to the patients, once some doctors began to realize that it was impossible to treat the problems of their patients without having human contact with them.

The fundamental function of the staff was to control the patients, and they found themselves having to manage a large number of patients whose histories (and often whose names) they did not know. Solazzo remarked: "Every one of us had before him an anonymous mass of 150 or 200 patients, many of whom we didn't even know by name." Savoia described the function of the psychiatric nurse, stating that these nurses represented "the connecting link between supervisors and nurses. Their function was almost exclusively one of vigilance", He noted that the assistants were "the only ones who entered somewhat into relationships with the patients". The psychiatric nurses passed on the directives they received from the higher level of the hierarchy, and the assistants carried them out, or had the patients carry them out.

Savoia added that "at times the feeling we had, in our relations with co-workers, was that of a barracks: dialogue occurred between those at the same rank or, at most, with direct superiors and inferiors. It was difficult to jump over a level of the ladder, unless it was for an urgent need or a special activity. And it was always superiors who addressed those at the level below. But it was not rare to have a particularly close relationship with individuals from the lower levels. I, for example, always tried to remain as close as possible to the patients. And often I managed to have a direct relationship with them, based more on sympathy and personal choice than on therapeutic considerations.

Solazzo defined the role of the assistant as being dedicated to "the details of care for the patients and their environment. My co-workers and I were the people closest to the patients. We who those who most commonly came into contact with them. I was assigned to the second men's building. There we kept watch, making sure that they did not fight, that they weren't dirty, that they ate properly and that they were accompanied in their daily activities, which they carried out like robots, or troops in formation. In the early 1970s, the orders were given to us by nurses, who we referred to in all cases. I rarely remember interacting with supervisors (who often were closed in their rooms), and almost never with doctors".

A comparison with recent studies of the culture of contemporary mental health services shows links to this experience: indeed the hierarchical culture is one of the distinguishing characteristics of these services, along with the values and ideology which predominantly characterize the nurses in the CSM (cf. The cited study on CSM and on SPDC).

Control

The most fundamental element of the culture was control. The three interviewees helped us to understand how control pervaded the entire organization of the hospital.

For Rollo, the OPIS "was organized as are all "total institutions" in which it is important to maintain control over people perceived as dangerous. This control, which was exercised at all times, required a capillary and strongly hierarchical organization. The nurses were organized into three shifts; at every shift change the patients were counted: they were made to line up one after the other, and were counted by putting a hand on their shoulders". Only a small number of patients were permitted to leave the buildings via the central avenue, and while some were allowed to move around by themselves at specified times, others always had to be accompanied. In those years, patients deemed suitable were allowed to leave the facility's grounds on an experimental basis. These trial efforts were highly bureaucratically complex due to the demands of responsibility for the patients, and the dangers which could be incurred in allowing patients access to the outside world. Rollo believes that the constrictive environment of the hospital was particularly significant: "the staff, above all the nurses, but also some doctors, lived in a climate of fear. They were very much concerned with the respect for and observance of the strict rules that were in force. Naturally there were some significant exceptions, especially among certain doctors who had for some years taken on the responsibility of arranging for the patients to spend time on the outside, with an understanding that was ahead of its time about the importance of human contact in psychotherapy. But there was great fear of responsibility. It often happened, for example, that after I had decided to arrange an excursion for a group of patients I received a letter, also sent to the law enforcement

authorities, in which the administration affirmed that the responsibility for this decision was entirely my own.

Oriented in this way towards control, the OPIS “did not focus on the patients, and did not aim at curing them, but limited itself to controlling them” (Rollo). The organizational structure did not allow the human contact with the patient fundamental for treatment. One need merely consider the numerical relationships-- two doctors and at most four nurses for every 200 patients—which made relationships between staff and patients extremely difficult. Rollo highlighted this aspect as a particularly problematic one, given that psychiatry is a discipline which relies on a personal relationship with the patient. Rollo stated that the only way to try to overcome the limitations created by the number of patients was to “not to simply examine them, but to spend time among them”. However this was not easy, because the nurses attempted to limit contact between doctors and patient for reasons of security. Rollo described having had to struggle to get access to the central room in which all of the patients gathered to watch television, and to explain to the nurses that he would not be in danger, and that only by doing so could he perform his duty as doctor.

Valorization of human relationships and social/recreational initiatives

The valorization of relationships with patients developed in the field and derived from the psychiatrists and other staff who had daily and direct contact with the patients. In the 1970s recreational and entertainment initiatives continued and become more organized, as did work therapy.

Over the years the facility was enlarged and renovated in response to the growing number of patients and the culture change the hospital experienced. Along with the structures necessary for its basic functions, like kitchens, the laundry, and the diagnostic labs, a garden (used for work therapy), a theater and a movie theater (used to entertain both patients and staff, and athletic facilities, including a soccer field, were constructed. In that period in the first building, Professor Rodolfo Belsanti attempted a series of “experiments” involving both work and play, which involved the participation of both patients and staff (Solazzo). Here a soccer team was created which from the start included three patients. The team, in which Solazzo played (and about which he spoke to us), along with Professor Belsanti, practiced and played on the field of the OPIS. The other patients were authorized to take turns watching the games and practices. In addition to soccer games, minor maintenance work was done with the assistance of the patients. Along these lines Solazzo recalled that he was given the task of repainting the perimeter wall of the entire hospital, and was permitted to chose a group of patients to work with him. In reality, the objective was not the work itself, but the involvement of the patients. Finally, some patients, called “workers” took care of the OPIS’s garden.

Moments of humanity

Savoia: “I have to say that the asylum was a harsh environment. Nonetheless the solidarity and humanity which the patients established among themselves impressed me greatly. I particularly remember two significant episodes, linked to patients under my care.

At a certain point, we realized that bread was disappearing from the dining hall. After a series of ‘investigations’ I discovered that a patient from the second building, one of those considered to be most dangerous, was smuggling it out hidden under his clothing, and distributing it to his fellow patients who were confined to bed by therapy. It was a very moving thing.

The other episode still moves me: I had made friends with another of the ‘dangerous’ patients, who after years of silence and a nearly cataleptic state, little by little began to trust me enough to tell me the story of his life. He had been admitted to the asylum when his wife was several months pregnant, and he had never seen his daughter. His family, in the years following his admission to the asylum, had never come to visit him. So one day, I decided to take on the responsibility: I asked for the dozens of authorizations needed (including from my supervisor, Professor Bianca Gelli, and from Director Sinisi, who authorized the asylum’s driver to go with us) and we set out for Brundisium, while my colleagues continued to say ‘Who is making you do this? Why do you take

on all these responsibilities?’ Along the way we stopped at a bar; I lent him 10,000 lire, and told him to buy something for his daughter. He bought some candy. When we arrived at the house, the driver and I had to calm his wife and assure her that we not bringing her husband back and that it was only a visit of a few hours. As soon as the patient saw a little girl about four years old, he ran to her and embraced her in silence. He held her for a few minutes while the other relatives attempted to make excuses for never coming to visit him. He ignored them completely. After a short while he got up and said ‘Now we can go. I’m the happiest man in the world. I wanted to meet my daughter, and I don’t care about the others.’

I am telling you this to show how much prejudice, from society and from their own families, existed for these mentally ill people. It was a lesson for doctors, nurses and social workers.”

Unfortunately it was not only the asylum which limited itself to containment of patients, but society as a whole which preferred to confine them at its margins.

Conclusions

The recovery of this experience causes us to reflect with bitterness on the results of the actuation of a culture of control, and of the expulsion of difference from society--a culture often invoked even now.

In the last phase of the history of the asylum, interventions into mental health were on the one hand medicalized, with employment of pharmacotherapy, while on the other hand recreational and social treatments made headway. These two tendencies still characterize mental health treatment, particularly in Apulia, as we will discuss in the sequel to this work.

It should be noted that through the years the culture of the OPIS remained strongly tied to the mandate of protection from the dangers posed by the mentally ill, and while medical treatments have changed with progress of pharmacology, they remained oriented toward maintaining control of these persons, and making them manageable.

Through the course of history, a psycho-social interpretation of mental health problems seems notably absent. This is not surprising if we consider that psychology, over the years, has given up on the possibility of contributing to the analysis of such phenomena, taking refuge in the niche of the psychotherapeutic intervention which is often focuses on a single individual, considered without regard to the context in which he lives. There is no use of a psychosocial model aimed at intervening in the relationship between individuals and the contexts (family, work, friends) in which psychiatric crises arise.

At this point it is also worth noting that these two tendencies (medicalized treatment and entertainment) have developed in entirely different spheres: the former comes from the environment of scientific knowledge, while the latter has developed in the field, derived from experiences of everyday relationships with mentally ill patients, and is oriented by common-sense considerations or influenced by sociology. This is particularly significant if we consider that sociology provides tools for the analysis of social phenomena, but does not have a theory of the relationship between individual instances and social contexts, nor, above all, a theory of intervention. In other words, it can be said that initiatives were undertaken which were seen as potentially useful, not on the basis of a theory which would permit the connection of such experiences with hypotheses about the problems.

In the second part of this work we will compare the considerations that have emerged from the history of the OPIS with a contemporary reflection on the functioning of services for treating mental health problems.

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