"GOOD PRACTICES" MEANS "OPEN DOORS WITH NO RESTRAITS" AND "COMMUNITY BASED"

When we talk on the operation of a psychiatric unit, and mainly of an acute unit, with "open doors and with no restraints" (and no seclusion), we refer to the deconstruction and surpassing (going beyond) of the most visible restrictive forms of internment, as a first moment of a practical, and not only verbal, questioning of the dominant psychiatry.

This is because the "locked" or "open door" does not exist only in its physical, material form, but also in the "minds", the mentality, the culture, the "way of thinking". It has to do with the concepts, the ideas that contribute to the formulation (and cultivation) of attitudes and practices which tend to entrench and emarginate the person with "mental health problems" in, or out the community. Based on these concepts and attitudes, criteria are raised for inclusion or exclusion, by extending further the classification approach from the Diagnostic Manuals to the practices of the Rehabilitation itself.

The "locked" or "open door" has to do mainly with the social mission and the content of the psychiatric practice in its wholeness, in all its aspects. It has to do with the crucial question of power relation between those assigned for the management (and control) of the mentally suffering person and those who are subjected to this management and control. This kind of relation makes up the constituent element of the so called 'therapeutic practice' and of the various technical approaches through which it is exercised.

Since, in most cases, the so called modern, 'open' community services, account on and rest upon the backs of a psychiatric hospital (or of the similarly functioning locked psychiatric clinics in general hospitals), the "locked door" regards also them, penetrates and pervades also their function, it cancels, also, their own therapeutic potential, because it constitutes, even implicitly, part of their reasoning for any 'case'.

We always considered restraints as the outmost of the cancelation of the person's dignity by dominant psychiatry. As a practice that reflects its theoretical and therapeutic poverty and its inability to confront (through a relation between equals), the person with mental health problems as a subject, as a human being in its existential and social wholeness, with multiple needs but, also, (subject) of rights which have to be respected the same as for everyone.

The problem with restraints has not to do only with the "by effects" of the "method", that is, with the fact that many people have lost their lives and still continue very often to die because of the restraints.

Neither it is a question of "correct implementation" of the "method", through following strictly the guidelines of a protocol, which will regulate its use and will permit its implementation only in cases of "emergency". Because its main "by effect" is its "desired effect", its action and implementation itself.

As regards Greece, there was a period, from 2000 onwards, that was in progress a ten year program for "psychiatric reform", co-financed, as always, by EU and which had as final target the closing down of the five smaller mental hospitals until 2006 and of the three bigger ones until 2015. Since the great majority of the psychiatric community never demanded, or moved beyond an "area of interest" that was waving between an irreversible old-institutionalism, to, at most, a superficial and simply verbal adoption of the theory and practice that put this old fashioned institutionalism into question (which means, promoting an "new fashioned" institutionalism), the result was the whole reform venture to be reduced to a mere relocation (rehousing) of long term wards internees in mental hospitals to community residential units, hostels

etc (with a large part of them assigned to NGO's), without the creation and establishment of a comprehensive and community based mental health system of services. There are very few, poorly functioning, Mental Health Centers and Mobile Units, with a marginal function in the whole system, there was never a sectorization of the services and 65% of all hospitalizations in mental health are involuntary (executed exclusively by police, with handcuffs etc). The associations and movements of users, families etc are becoming all the more weaker as the time goes by and are usually used by the various dominant authorities as "laundering" for their predetermined authoritarian procedures, in the Ministry etc, but, also as a façade (a front window) for various NGO's.

It was in such a context, that, in 2004, started its operation the admission unit of the 9th department of the Psychiatric Hospital in Athens, almost simultaneously with the establishment and operation of a community Mental Health Center (from 2006). These units came after an effort for deinstitutionalization, from inside the mental hospital, starting with the closing down of a long term ward, with its internees going in community residential units, hostels, group apartments etc.

From the first moment of the 9th admission unit operation and for a quite long period, a big effort took place from the part of the equipe for the abolition of restraints while, simultaneously, maintaining the door open, from the morning until evening. As in almost all admission units in Greece, the number of the hospitalized persons ranged from 30 to 35, while the nursing stuff were in the beginning, 17, to be reduced, after some years, to 13. It is obvious that the percentage of the number of beds (inpatients) with that of the stuff, especially the nurses, was in diametrically opposite direction from that which is required in order to have the quantity parameter required for a practice of complete abolition of restraints (a parameter in connection, of course, with the primal role of the quality factor, which consists to the adoption of a "policy", of a therapeutic "thinking and practice" radically against restraints).

Since it was the only admission unit in this Mental Hospital (and also all around the country) that was functioning in this way, this had as a consequence its own existence to be a kind of continuous, visible, dissonance (the "constant risk", a "continuously problematic situation"), receiving and all the relative, to this approach, answers and attitudes from all grades of the established authorities inside the Mental Hospital. That is, it was functioning on the basis of a condition not of acceptance, but on one waving from being openly hostile and undermining to mere tolerant - a situation which of course was reflected inside the equipe.

Crucial points for the implementation and success of this venture were, first, the interconnection of the admission unit with the Mental Health Center, the pursuit for both to exercise their work on the basis of a certain sector (catchment area) and, in any case, the unified and interconnected way through which the equipe was functioning in all interconnected units.

The reasoning on which the Mental Health Center (MHC) was established, had to do with the ***deconstruction*** of what constitutes the practice of ***internment***, in its nucleus, which is the concept of ***protection mainly as guardianship*** and of ***therapy interwoven with deprivation of freedom***. In every process of a real transformation (and not of mere embellishment), the element of protection has to be maintained, but unblocked from any repressive element and under radically different terms: that is, it has to be provided in strict connection with the freedom of the person (through a relation of dialogue and negotiation 'between equals' with the person).

This freedom, however, must not become equivalent to abandonment, but connected with the all sided support and accompaniment of the person/subject in the community.

So the reasoning for the MHC was based on the idea that what was at stake was not the establishment of one more community unit in the logic of a parallel and disconnected functioning, an approach that would leave ***untouched the hard core institutions,*** but a community unit that would be, in itself, a moment, an instrument and a product of the ***surpassing (going beyond) of these structures and the practices*** whose inextricable part are these structures of hard institutionalism. We are talking for a community unit that would not reproduce the well known model of ***'community units' as ambulatories,*** which, in this way, eternalize the need (and function in the service) of the Mental Hospital (and of hospitalization), instead of going beyond them.

There were some crucial points among the rules that we considered very important to be incorporated in the constituent statute of the unit. These rules constituted the axis, the ground on which the function of the unit with "open doors and no restraints" was based, which means, the kind of relations that compose and are interwoven with this way of function.

One of the primary rules was the recognition of the need to take always into consideration the detachment of the person from his/her particular context and the danger arising, from this, to to be subjected to the dominant procedures of an excessive medicalization of his/her problems.

Another rule was that it has to be avoided any uncritical submission/compliance of the patient to the rules of the department, through submission of his/her particular and concrete needs to these general and abstract rules. Usually these rules are inflexible, structured on the line of dangerousness and of control, of the disciplined daily life, of efficiency and effectiveness, on the basis of which the mental health units are organized (but, very often, also the residential units) - rules which are very often traumatic for the self esteem of the patient.

Attention was given even to external view of the department, by avoiding railing, bars etc.

Emphasis was given to moments considered as important such as the moment of the *reception* (*welcome)* of the new patient entering the clinic and, generally, the way of approaching him/her (before and independently of any medical examination), so as to establish a relation of mutual acquaintance. And in connection with them, the development of trustful relations, the accessibility and the availability on part of the stuff (nurses, doctors etc) to hear and answer to expressed needs, desires etc, and of, course, respect to his/her rights and his/her social roles (family, work etc).

In conclusion, what is of crucial importance is the ***adjustment of our operation (of the institution) to the particular needs of the inpatient person - instead of the opposite***

Integral part and of crucial importance for the operation of a psychiatric unit in this direction, is the ***strengthening and upgrading of the nursing stuff role***, as also the functioning of the equipe (interdisciplinary team) through a more or less ***horizontal hierarchy,*** which entails more participation of all professionals with different specializations in taking decisions and a redefinition of all established roles.

As was referred before, the hostile atmosphere in the context of which this venture took place, notwithstanding its successful outcomes, contributed, after about ten years, in connection and interaction with the outbreak of the economic crisis and the imposition of the successive memorandums in Greece, to the closing of its cycle, to its end.

Maybe the most concerning point of the modernized, as a façade, but extremely repressive psychiatric system in Greece, is that there is no any questioning, "from

inside", of this neo-institutional construction. Restraints, the "one way therapy" based almost exclusively on medicines and "revolving door" are the self evident and uncontested "therapeutic" methods - with a diffused hostile position even to any allusion for sectorization of the services, shift to the community, no use of restraints. The mental health services are dramatically understaffed, due also to the economic crisis and the memorandums, involuntary hospitalizations immovable in their high (65%) percentage, all psychiatric departments with a lot of added beds (camp beds) [it happens often in psychiatric acute departments, in mental hospitals or in general hospitals, to be added to the regular number of beds (usually form 20 to 27), 10, 20, or even 30 'camp beds'].

In the period between 2013-14, the rightwing government (similar to the new government that was elected after the July of this year elections in Greece) was trying to close down the three still existing mental hospitals in a very hasty way, in a few months, while there were not at all any alternative services, community based etc, that would replace them, not any program, any intention, or any interest existed to create them even in the distant future. When after the elections of January 2015 the so called "left" took the government, this abrupt closing down of the MH's was postponed (in agreement with Brussels) for many years (maybe until 2020), but, again, no community services were created.- What we had, for about more than four years, were just verbal references to the need for "completion of psychiatric reform" and various plans and administrative regulations for community services, "catchment areas' (with population from 200.000 up to even 400.000 inhabitants), but just on paper, without any attempt for implementation. No new services, not the slightest change in the way the system functions, in its "culture and practice".

So what we have now is the consolidation of what has been called "modernization of the dominant psychiatric paradigm", which consists in the incorporation and assimilation in the dominant, authoritative practices, of a part of the opposed and radically alternative positions, through an open or smuggled alteration of their authentic content. Without of course this modernized dominant psychiatry to stop being based on the "old fashioned" practices - those practices against which declares (just verbally) a critical position.

This was expressed in the position that some so called "modernized" agents, NGO's etc, took in relation to some supposedly "reformation" attempts by the "left" government, which did not become possible to be implemented because of the recent elections and the government change. One of them regarded the introduction also in Greece, of the "compulsory community treatment" (Compulsory Treatment Order), a very well known, measure, of neoliberal origin, that consists in the diffusion of repressive practices in the community, as the only response that the psychiatric community and the Greek State can conceive in order to diminish the high percentage of involuntary hospitalizations and for the management of the eternal perpetuation of the "camp beds problem".

In the same draft bill a provision was introduced that regarded a change in the way the involuntary hospitalizations are still executed in Greece (as already referred, exclusively by police, with handcuffs etc). The bill provided that involuntary hospitalizations, from now on, should be executed by the stuff of the Emergency Service, with the ambulance they use, which, however, in the case of involuntary hospitalization of persons with mental health problems, should be "properly formed inside" - and with the help of police when it would be judged as necessary. They never clarified what was meant by "ambulances properly formed inside".

What is interesting are the comments expressed by the university psychiatric community in relation to the second measure (execution of involuntary hospitalization) in the public consultation of the bill (which did not manage to go to parliament because of the elections), that "the execution of the involuntary hospitalizations by the police must not change because the paranoid patient must see the policeman in order to be afraid" (Pavlos Sakkas).
While, at the same time, some "modernized" and "innovative" NGO's openly supported the "compulsory community treatment", some of them advising the measure, in order its success to be ensured, to be introduced gradually and not abruptly!!! (St. Stylianidis, EPAPSY).
All these are taking place in an epoch of a deep economic, social, political and cultural crisis, with a shift towards conservative tendencies and the rise of the various far right and racist formations in many countries, while, at the same time, we experience a diffused, and in various forms, social desperation, which is fostered, also, by the lack of a visible, alternative and emancipative, perspective out of this crisis. It is this situation that, in our opinion, brings again to the forefront the need, if we want to be really radical in our practical critic to dominant psychiatry, to go ***back to the roots*** – and these roots are the tradition of Franco Basaglia and the Italian Democratic Psychiatry, but also of other relative tendencies (Hearing Voices etc).
Because the ***therapeutic dimension***, as Basaglia emphasized, has a ***technical*** and a ***political*** element. It is a big illusion, as our experience has shown in Greece all these years, to see the transformations in mental health as a mere dissemination of the new, "good practices". The absorption of the political by the technical element leads to the atrophy, to the mutilation of the critical position, to the undermining of the therapeutic dimension. It leads, that is, to the reproduction of the "old paradigm" in a new form, so as to become more effective to the new needs of the dominant system for social control.
So, concluding, in the situation prevailing not only in Greece but in whole Europe (and not only), full of traps for mental health professionals/workers, especially for all those who try hard for the establishment and function of mental health services on the basis of a quality whose primary aspect would be the respect of the rights and the real interest for the person, it is very important to have always in mind that although we try to extract and get the most possible from the system for the therapeutic and social interest of the person, we must not participate in the reproduction of illusions, promoting our practices, independently of how "good" they happen to be, to a panacea that solves all problems. Having in mind the limited scope even of the most "good practice", we must keep the ***contradiction*** (inside which we operate) ***open*** and to enforce our critical approach and demand. As Basaglia said "***the politicization of our of our practice is still the only therapeutic practice,*** that can be conceived and which coincides with the disclosure - in all levels of the community- of the most serious, hidden contradictions of our system".

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Theodore Megaloeconomou