When the city heals.

Beyond the politics of welfare. Towards an ecology of care.

Community Healthcare Services and its Potential for Social Transformation.
Empirical Research departing from experiences in Trieste/Italy

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Is it possible to imagine "welfare" as a dynamic and distributed practice of care and emancipation? Can we socially unlearn both the neoliberal individualistic and the social-democratic prescriptive modes of welfare provision? Can we start to inhabit and institute a difficult, but possible, ecology of care? This report analyses the practices of community healthcare in the Trieste Public Healthcare System as a possible gateway of recovery and emancipation, out of the contemporary crisis of Mediterranean Europe.

The question is: have we been able to institute an organisation that perceive the needs? Have we been able to develop a system of antennas and networks? Are we walking a useful path? [These] services are not looking at society from the outside; they are constituted as a gaze that enter and becomes part of the stories, that participate in producing those subjects and subjectivities that your stories recount. These services are doing their work, or at least I feel the stories you recount are telling us that the services are doing their work, that is to shift from a medicine of death to a medicine of life, from a medicine of naturalisation to a medicine of subjectivation. Conscious of the biological body, of the biological techniques, but also conscious of the fact that when we talk about a disease we are talking about an institutional artefact, a social and cultural construction that emerges in the composition of many variables. [...] If you are taking care of somebody in the hospital, you see only the ward and the body: the hospital is always the same, the person changes but you do not need anything else. When you take care of somebody at home you are obliged to look at where she lives, her environment. You cannot take care of her without encountering with the family and the neighbourhood, and without acknowledging that there is nobody around her, when nobody is there. The world in which the subject lives becomes part of your notebook: having and not having, being and not being are crucial elements of the recognition of the problem, of diagnosis and prognosis. If you want to do anything, you need to activate the resources of the context and the story of each person, her capacities, because these resources, these capacities are the one that can help to imagine a better healing.

Franco Rotelli in a conversation with Giovanna Gallio in *Servizi che Intrecciano Storie: La Città Sociale, 2013*

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Introduction

At stake today is the necessity of a new imagination of welfare through the crisis; or in other words, the possibility of a different practice of care in our everyday life. The construction of a dynamic and distributed practice of care is today a challenge for the European left. This possibility can become real only encountering concrete practices and alternative imaginations that can provide gateways of recovery, out of the contemporary crisis.

The Mediterranean European political space constitutes indeed a crucial site for imagining a future of emancipation for Europe, a recovery that is an opportunity for democracy and of transformation for the better. In this context, contradictions and possibilities overlap and define an ambivalent space where the European crisis is more profound, but also where it is possible to imagine another Europe in a very concrete sense.

The collapse of the post-industrial mode of production is clearer in the southern cities than anywhere else in the old country: the crisis of the universal access to services and public provision of mutual support is affecting the everyday life and the constitutive tissues of social life; the traditional political systems are experiencing a radical crisis of sense and functioning; the shores of the Mediterranean sea are the vivid image of the dramatic effects of the contemporary European governance. As a consequence, the economic and social crisis in the periphery of the Union, the widespread corruption of the European and national political systems and, last but not least, the dreadful Mediterranean crisis have constituted the ground of a profound ambivalence in the south of Europe: not only and dramatically being the pretext for a fascist and racist mobilisation of fear and hate; but also constituting the ground for a frail but determined bottom-up production of a different understanding of care, rights and social change.

Health and care become the space where experimentation is necessary, because at stake in the crisis is the bare life of the people: here experimentation is possible, because the political engagement with the practice of health involves a material production of another way of caring for each other.

In order to address this question, my report engages with the experience of Trieste, a forty years long practice of radical public policies in the field of healthcare, with the objective of unveiling a radical emancipatory form of regulation and governance of welfare policies: it analyses Healthcare System of Trieste and the way in which the Franco Basaglia equip has reinvented the practices of health and care in the urban space since the 1970s. I address Trieste as a "singular governmentality" that, in the last decades, has been practically experimenting with a different logic and functioning of the state-machine in healthcare, and dealing on the everyday level with a radical transformation of the effect of the state on the people's life, in the city of Trieste.

In Trieste, in 1971 there are 1300 inmates, to whom freedom and dignity are denied, on whom violence and torture are allowed. More than a hundred thousand across Italy. The only

way out of the loony bin is death. This situation of segregation and violence triggers one of the most important and radical movements in Italy, initiated by Franco Basaglia and others, that led to “the destruction of the psychiatric hospital”. In 1978, the Italian legislation granted to close all asylums; internment is forbidden; civil, social and political rights are recognised to the “loonies”. After the dismantlement of the Psychiatric Hospital in the late 1970s, 24/7 local centres decentralised care, and social cooperatives were organised with the support of the Department of Mental Health in Trieste. Educational grants, community budgets, economic mechanisms and housing projects supported the urban life of users. Since the early 2000s, this logic of care affirmed by the Basaglian movement has become a governing force of the social healthcare system of Trieste and the Friuli Venezia Giulia in general.

My report aims to **provide a general genealogy** of the context in which this model emerged and the actors that made it possible, **diagram the functioning** of significant devices of this healthcare system today, as well as **identify the crucial elements of tension** of this model, both in relation to the contemporary governance of the crisis and as possible escape routes of emancipation.

I focus on how this model of health and care is functioning in the wake of the crisis, by widening the radical reorganisation of welfare practices from mental healthcare to community healthcare and recently to the regulation of the whole Regional Health System. In order to do this, after focusing on the critical debates on citizenship welfare and healthcare, and after introducing the singularity of Trieste governance of health and care, I focus on the Healthcare District as a device of intervention and specifically on the Micro Area Programme developed since the early 2000s as the ground for proposing “ecology of care” as alternative but pragmatic approach to the politics of care in the city in response to the dramatic effects of the neoliberal dismantling of the welfare state, but also as a critique to the prescriptive acting of social-democratic welfare policies as hegemonic understanding of emancipatory policies, for the left in Europe.

My research developed over three months: the first was dedicated to desk research, and to organise the fieldwork (both logistically and methodologically) with the support of the School of Management of the University of Leicester. After a few weeks, I started my fieldwork in Trieste to enquire the model of mental healthcare and general healthcare; in order to do that I interviewed a total of 28 significant actors (15 of which on the Micro Area programme, the specific focus of my research)[1]; I participated in a two months mapping project of the Peer-Support Group in the Mental Healthcare Centre of Domio (which outcome will be soon published online) that allowed me to participate directly in the dynamic of the Centre in Domio and the Department of Mental Health in general; In the meanwhile, I spent two weeks per site in the Microarea of Ponziana and Zindis and, later, I organised a series of internal workshops with the workers of the Social Healthcare System following a co-research

[1] 1. The list of the interviewees is the following: Microarea and Social Healthcare System: Margherita Bono, Maria Grazia Cogliati, Michela Degrassi, Claudia Ehnrenfreund, Giovanna Del Giudice, Sari Massiotta, Barbara Naglieri, Flavio Paoletti, Lorella Postiferi, Monica Righetti, Federico Rotelli, Mario Reali, Federica Sardiello, Alfio Stefanic, Davide Vidrih; on the Mental Healthcare system: Valentina Barbieri, Giancarlo Carena, Elena Cerkvenic, Roberto Colapietro, Guillerrmo Giampietro, Ecatariana Margina, Roberto Mezzina, Sandro Metz, Pina Ridente, Michela Rondi, Franco Rotelli, Nicole Schneider, Davide Vallefuoco.

methodology (two of which were held in July and two of which will be held in October). The last period of my research with the support of the Kent Law School, University of Kent, in Canterbury, was dedicated to write this report and to develop the website “voci di microarea” which publication is pendent to be discussed and approved with the co-research group mentioned above.

For the possibility of developing this research, I am particularly grateful to Giovanna del Giudice, Isabell Lorey, Barbara Fried, Marta Malo, Marta Perez, Dimitris Papadopoulos, as well as Donatella Alessandrini, Emilie Cloatre and Gavin Sullivan for the discussions and help and for the institutional and academic support.

My work in Trieste has been possible thanks to many groups and persons, without whom my research would have been scholastic and shallow: the World Permanent Conference for Mental Health; the Direction of the Department of Mental Health, the Mental Health Centre of Domio and the Peer-Support Group based in Barcola; the Coordination of the Micra Area Programme of the Social Healthcare System as well as the Microarea of Zindis, Ponziana, Campi Elisi, Gretta, Melara, San Giovanni, Soncini, Valmaura, Vaticano; the Social Cooperatives La Collina, Agricola Monte Pantaleone, Duemilauno Agenzia Sociale; ‘Escuchame’ and Radio Fragola, Il posto delle Fragole, the Association Volontari Franco Basaglia. I want to thank Valentina Barbieri, Margherita Bono, Giancarlo Carena and Claudia Ehnrenfreund, Maria Grazia Cogliati, and Sandro Metz for the discussions, generosity, help and support.

The frame of welfare models

In the contemporary crisis, the practices, the spaces and the resources of healthcare constitute a privileged point of view to look at the effect of the “state" on the life of the people, in the words of Timothy Mitchell, and to imagine new ways of social organisation, capable of responding to the needs and desires of a European society undergoing a profound transformation. The experience of Trieste has been an attempt of disarticulating both the neoliberal and the social-democratic logic of welfare through the affirmation of a pragmatic diagram of politics and ethics of care, of emancipation and of social reproduction.

In particular, as a frame for analysing the experience of Trieste, I address how its rationality and practices allow us to challenge the regime of truth embedded in two of the most significant European analytical frames of welfare, namely the 1960s universal model of a citizenship, i.e. the industrial full citizen of TH Marshall, and the sociological 1980s analysis of welfare as plural mode of governance, i.e the *three worlds of welfare* of Gøsta Esping-Andersen. In order to imagine another functioning of common care and social emancipation in this context, I sketch here the possibility of imagining Mediterranean politics of care today as a space where to analyse a different and constituent mode of organising health and care in the wake of the crisis.

Beyond the logic of welfare

It is important to situate the Trieste experience as an anomalous "counter” practice of welfare, beyond and against both the neoliberal and the social-democratic logic, beyond any entrepreneurial or paternalistic understanding of the practice and the effect of the state. Trieste, as I pointed out in the introduction, constitutes a "singular governmentality”, that is a repertoire and assemblage of rationalities, truths and ethical principles, but also a catalogue of practices, protocols, sites, experiences that define the material invention of a different understanding of healthcare, of welfare and, at the end of the day, of *citizenship* itself.

For this reason, it is necessary here to situate this practice in contrast with the hegemonic models of welfare in the Fordist and post-Fordist European and social-democratic left: the Industrial Citizenship of TH Marshall and the Three-Worlds of Capitalism of Gøsta Esping-Andersen. This counterposition permits to defy a conception of the welfare state system built upon the subordination of agents, on the stratification of rights and on “lack” as rationality of citizenship. Instead affirming a contingent understanding of welfare and care as social production and reproduction immersed in the conflictive life *of the city*.

The singular governmentality of Trieste indeed questions the TH Marshall logic of full citizenship at the roots. The model proposed by TH Marshall in the early 1950s has been the basis of the social-democratic understanding of welfare not only in the Anglo-saxon world, but generally in the European and American debate. The focus of TH Marshall is on the construction of social rights in the aftermath of the Second World War and in the reconstruction of Europe, as a new mode of social organisation of production. The

Marshallian lectures of 1950 define social, political and civil rights as parts that constitute the ground for the definition of an industrial citizenship, organised around a full citizen in his rights and his duty towards the rest of society: “full and equal membership in a political community”. The Marshall conception of citizenship is constituted therefore as teleology of rights: a practical (and inevitable) fulfilment of an ideal imagination of rights.

The struggle for the civil rights of the 18th Century defines the ground for the affirmation of the individual right to property. In the 19th Century, the realisation of the Parliamentarian organisation of political rights; after the Second World War, the proposal of social citizenship theoretically underpinned Keynesian policies, as policies for progressive and universal inclusion of the population in social rights against the inequalities produced by the capitalist market.

At stake was the imagination of a social system where classes would cooperate within the Fordist mode of production (Mezzadra, 2002). Industrial citizenship constituted therefore the utopian horizon for the political struggle of workers - organised through parties and represented in political institutions. The mechanism of representation - capable of constituting the Nation state as the homogeneous image of civil society - supposedly entitled the people to a definitive social contract of unconditional and universal rights.

This conception of citizenship has been widely criticised. One critique is particularly important here: the one that recognises how the Marshalling citizenship is constructed around a homogenous conception of the citizen. The teleology of rights indeed is converging another (and not explicit) totalisation process: the one that breaks the tiers of class exclusion, of racial segregation, of gender discrimination: everybody will be a citizen in the moment in which s/he will be made equal to a white, economically independent, male and productive body.

The Basaglian conception constitutes another ground to be a citizen: the starting point of the Basaglian reflection is indeed the negation of the fool in the asylum as citizens and their construction as outcasted, as internal outsider of a society. The question of citizenship therefore becomes the following: How can a loon be recognised with social, civil and political rights, without being excluded or normalised? How can the welfare state support the constitutively difficult freedom of urban life instead of constituting an homogeneous citizen entitled with rights?

A second and structural criticism has been raised against the Marshall conception of citizenship, from a sociological point of view: the production of citizenship, and welfare in particular, is the result of a social production of conflicts and negotiations, of arrangements and assemblages that configure a plurality of welfare system. Although a different set of debates have been dealing with this plurality of welfare system, from the regulationist approach developed by Michel Aglietta and Bob Jessop - that constructed the basis for an analysis of governance as a system of power that intertwine political, economical, institutional and cultural dynamics - to the Scandinavian debates (Claus Offe analysis of the contradictions of the welfare state in guaranteeing access to right and disciplining social

production and social conflict), the dominating discourse about this plurality of welfare system can be recognised in the Gøsta Esping-Andersen system of three worlds of welfare.

In Esping Andersen analysis, three different models welfare have been depicted: the first based on a social-democratic universality of rights (the Scandinavian one), the second on a corporate composition of interests (the continental 'German-French' model), the third on the individual guarantee of equal opportunities (the Anglo-Saxon 'world'). In this model again a convergence in the social organisation of production and in the provision of welfare services can be recognised, not according to a singular teleology of social dynamic, but rather to what I would call an entropic tendency of social conflicts.

Every other political space, in the rest of Europe, and in the rest of the world, should be recognised as a temporary and marginal diversion from one of these models, towards which the other realities would end up converging. Whereas this modelisation has already been contested in the post-colonial and globalised world throughout the last forty years, the 2008 credit crunch and the austerity turn in Europe demonstrated that such a convergence is an illusion. In the analysis of Brett Neilson and Ned Rossiter, the Fordist model has always been an exception, in historical, geographic and social terms. Not only beyond the limits of the European economic and political space, where a multiplicity of temporalities intertwine, defining different models of social organisation based on colonial power, race supremacy and global inequality, but also this system of social organisation of production has been an exception in the western keynesian national system of the North Atlantic scape, both temporally - being this model valid only after the second world war and until the configuration of a neoliberal social organisation - and socially, since domestic labour, precarious workers as well as internal and transnational migrants have never been recognised full access to the rights of citizenship, even in the Golden Age of Keynesian Fordism.

The contemporary Mediterranean politics of care constitute an exception, that give us the ground to think the plurality of welfare as a multiplicity in the forms of care. I address here the welfare critique and practice developed in Trieste since the 1970s in accordance to a political critique of the welfare state as a prescriptive device to organise social production, the technician is functional to divide the sick and the healthy, the productive and the unproductive, the citizen and the outcasted, as Franco Basaglia and Franca Ongaro developed in "Peace Crimes" in 1974. Another understanding of care involves building services capable of supporting the "constitutively difficult freedom of urban life" Mariagrazia Giannichedda. A radical practice of health therefore involves not only a different understanding of biomedical practice and of public health. The crucial element is the invention of new institutions and legal practices: the definition of a different organisation of care that puts the technical practice of the welfare in the complexity of social reproduction, as a political dynamic of social change.

New politics of care

These new politics of care cannot be imagined and realised within a conception of public policies based on convergence, teleology, homogeneity and entropy, even when these

conceptions are disguised in the expression of universalism and civil society. The protocols of public policies and the provision of services indeed result from the material organisation of institution embedded in a system of social relations. In this assemblage of tensions, it is useful to translate a series of analytical and conceptual tools from the Indian post-Gramscian and postcolonial thinkers: concretely how they used the Gramscian distinction between a civil and a political society to understand the difference between the politics of the represented and the politics of the governed.

The civil logic of governance does not work in the “most of the world”, affirms Partha Chatterjee. Where “civil society” elects a series of “representatives” that govern institutions to respond to the claim of the “represented” through a *circular understanding of sovereignty*, the rest of society - the “governed” - has a pure political relationship with the state: they act in the material composition of the effective relationships of the social forces, as Gramsci puts it. From this perspective, politics and policies can be analysed as they act: the effect of the state is the effect of a series of not-only-public and non-sovereign decisions in a global assemblage of partial interests, corporate actions, throughout social turmoil, collective claims, subjective transformations.

Urban scale emerges as the ground of this conflict. A space where different levels of regulation intertwine and conflict: on the one hand, the logics of neoliberal globalization translate onto the socio-legal configuration of the city, where a series of public and private, international and transnational bodies play within the dynamic of the city: in the Trieste healthcare system, there are European and global public bodies such as the European Union, the World Health Organisation, but also pharmaceutical, biomedical and moral private corporations, as well as an international network of democratic psychiatric movements or structures. On the other hand, on the everyday ground, alternative ‘imaginations’ of welfare are enacted, in the quotidian assemblage of norms, agents, objects and places within the urban realm; they can range from refugee crisis committees to identitarian racist organisation, the Church and the social movements in a complex setting of practices and references.

Along this uncertain boundary of transition – in the specific case of Trieste, between stagnation and change—, this report **provides a genealogy** of the context and the actors that made it possible; it **diagrams the functioning** of the healthcare system today; it **identifies the crucial tensions** of this model in the context of contemporary governance and the crisis. My analysis focuses on how specific devices of community healthcare act within a neoliberal system of power and interests, and how these institutional practices also can transform the city, can produce social change, in the complex field that is “the social, bio-medical and legal construction” of health. In other words, the effect of the public provision of services to support the fragility of mutual care in the context of the crisis.

The experience of Trieste: from Mental Health to Territorial Health

A constellation of forces

The core of my report analyses the forms of social organisation of welfare that emerged in Trieste since 1971 after the arrival of Franco Basaglia as Director of the Psychiatric Hospital. It focuses on the contemporary relationship between the provision of general healthcare and the dynamics of urban space in the Microarea Programme and the District, looking at the dynamics of services, i.e the role of biomedicine and the protocols of healthcare provision, rather than to the discursive production of the Basaglian movement in Trieste. Although the three pillars of the Basaglian interventions should be stated: the deinstitutionalisation of healthcare, the subjectivation of users and workers, the social invention of new institutions.

Franco Basaglia is the initiator of a radical reform of the psychiatric practice, that moves step by step, from the dismantlement of the mental asylum towards the reorganisation of mental healthcare as a series of services, facilities and resources of support that intervene in the complexity of social life and construct the project of care around and with the user.

A few constitutive lines should be at least sketched to understand the space in which the Basaglian model has affirmed itself. The experiment of Trieste emerged in the general turmoil of the 1970s, when traditional institutions, of welfare (education, health) among others (family, labour, gender, race), were questioned; but this singular rationality of welfare needs to be situated today in the frame of the contemporary patterns of governance in the South of Europe. In the aftermath of the EC-IMF-ECB policy of control over national debts and of austerity politics, the dismantling of the welfare system has affected not only the provision of services, but also the legitimacy of public policy in taking care of society.

In the longer term, Trieste is space of borders: culturally, socially and economically determined by the shifting borders that determined its history, principally marked by the relevance of ist port for the Austrian-Hungarian empire during the 18th and 19th Century. This allows to frame the cultural relevance of its urban life, especially in the early 20th century (and significantly around questions of madness: James Joyce, Italo Svevo, Robert Musil among others) and its economically vibrant community and cosmopolitan social legacy, where Trieste has been the most important site of financial innovation, namely in insurance sector since the late 18th century.

Throughout the 20th Century, Trieste has been the border of the crisis of the empire, of the fascist regimes, and of the iron curtain, but also a space of convivence for different religions, different communities and cultures. The commercial decline as well as the industrial expansion of the city determined a rapid change after the second world war as well as the rise of identity conflicts in the city. The inclusion of Trieste, first as a free city and then as part of Italy has been the cause of the collapse of the international trade role of the city, that resulted in the crisis of the financial and insurance sector after the Second World War. The

Italian industrial development of the 1960s and the waves of relocation of Yugoslavian asylum seekers in the region of Trieste led to the development of steel factories and industries, that started to decline at the end of the 1980s. After the industrial crisis of the 1980s and the fall of the iron curtain, Trieste has experienced a long crisis, in economic and environmental terms as well as through the ageing of the population. In the aftermath of the Second World War Trieste has experienced conflictive political dynamics, since the identitarian and ideological tensions have been reinforced by the geopolitical isolation and the economic crisis.

In this *local* tendency, the Basaglian movement constitute a plural and global rupture, in the words of Franco Rotelli.

Since 1961 in Gorizia (close to Trieste), Franco Basaglia and his equip transformed the asylum into a therapeutic community, but also contested the relationship of power embedded in the practice of institutional reform. In 1964, "The destruction of the Mental Hospital as a place of institutionalisation" defines a new framework for critical and radical psychiatry. A phenomenologist, Basaglia distinguishes the mental distress and fragility of the patient from *institutionalisation*, identifying the latter as the main problem to end the dramatic and violent role of psychiatry (and medicine) in the delivery of care (and in the frame of the social-democratic rise of the Italian welfare state in the 1960s). In the “phrenologic” asylum, psychiatry is a practice of violence that roots its legitimacy in the totalitarian understanding of the relationship between society and the state. Deinstitutionalisation is not a practice of reform, but of destruction. The deinstitutionalisation of the asylum is part of a bigger picture, of a wider critique of medicine and of the welfare state.

A discussion that starts with the experience of Saint Alban and La Borde in France where psychiatrist like Frantz Fanon, Francesc Tosquelles, Felix Guattari or Jean Oury participated in a European debate with the anti-psychiatric critique of Roland Laing and David Cooper in the Kingsley Hall and the anti-institutional Italian movement, especially in Trieste, Trento, Reggio Emilia, Volterra and Perugia - Franco Basaglia, Franca Ongaro, Mariagrazia Giannichedda, Franco Rotelli, but also Giovanni Jervis, Mario Tommasini, Assunta Signorelli, a very dramatic debate now and then, as it used to be in the autonomous politics of the 1970s in Italy. It is also a space of discussion where thinkers such as Michel Foucault, Mony ElkaIm, Robert Castel and artists such as Marco Bellocchio, Ornette Coleman, Dario Fo and Franca Rame among many others participated.

Most of all, this different practice of care has been possible thanks to a new generation of users, nurses, doctors and citizens that inhabited the asylum since the 1970s until today, as a space of experimentation and discussion. Hundreds of volunteers, artists, activists, students and citizens throughout the 1970s and the 1980s forged the material realisation of a collective imagination of freedom and emancipation as the ground of care. The possibility of involving them as allies, parts and counterparts of the institutional management - in a material, technical and legal sense, as collaborators, experts and contracted workers - permitted an invasion and contrasted the crystallisation of the the mental healthcare system.

Deinstitutionalisation was calling for a practice of alter-subjectivation against the objectifying

mode of the total institution, a objectivation that not only affects the detained body, but the workers as technicians of oppression as well. Transformation can be achieved only on the limit of the institution. Against the objectification of their agencies, users and workers become protagonist in the production of public policies of welfare. A process that is constructed with and through social movements, medical critique, media campaigns, trials and conflict, legal production, institutional production. A process that involves the user as part of the care-team and that produces projects of recovery around the person and the desires s/he bears with her/him.

In 1971 Franco Basaglia is named as the Director of the Asylum with the political mandate of the Christian Democratic regional government of Michele Zanetti to close the Psychiatric Hospital. The inmates of the asylum are 1300 inmates, more than a hundred thousand across Italy. After a profound social, medical, political and mediatic effort, in 1978, the Italian legislation orders a structural reform, forbidding detention and contention, recognising the inalienability of civil, social and political rights of users, and most of all defining a protocol of transition for the dismantlement of all psychiatric hospital and the institution of local and community services together with a series of psychiatric wards in general hospitals. This process of emancipation involved not only a cultural transformation and a political struggle, but also the collective disobedience of laws and the production of new jurisprudence, one that permitted to legally recognise the social, civil and political rights enacted in the former asylum.

The application of the reform of 1978, that was regulated on a regional basis, is uneven throughout the1980s and the 1990s. The last Italian asylum closes officially in 1999, but the practices and protocols of actions are still very problematic in many parts of the country. It can be affirmed that different kinds of institutional critique and reform are hegemonic not only in Friuli Venezia Giulia, but also in Trentino, Tuscany, Emilia Romagna and Umbria (where specific movements have been present since the 1960s, cfr. John Foot 2015), as well as in Campania, Sardinia and Apulia.

After the death of Franco Basaglia in 1980, the radicality of this process has been reconstructed through mourning and a profound commitment of the Basaglia equipe, although this generated a series of ruptures in the group. The crisis was resolved in the affirmation of the urban logic of care. In Trieste the asylum closed in 1981 and care was decentralised: centres in each district of the city were open 24/7 with open doors, to get in or get out, sleep and shelter, or move out. Since the late 1980s, tens of social cooperatives are organised with the support of the Department of Mental Health as well as educational grants, community budgets, economic mechanisms of support. There are apartments, neighbourhood services, and mechanisms for family integration or for the independent life of users.

In the early 2000s, again, tensions in the leadership of the process caused a deep impasse in the project. In the reinvention of the project, a series of services of local care and public health have resulted from the invasion of the Basaglian critique into the general medical practice, especially through community healthcare and new legislative regulations, starting from the institution of the Social Healthcare District in the early 2000s, the Microarea

Programmes in 2005, and lately regulated with the Regional Law of Healthcare System Reform of 2014.

In the contemporary system, the subjective configuration of the workers in the public healthcare system of Trieste is heterogeneous: a first group, occupying relevant roles in the structure of care, proceed from the long trajectory of the Basaglian movement - some of them maintaining a political engagement with the whole system of health and care, some of them focusing on the development of radical but disciplinary practice of care, in specific branches; secondly, a group of professional proceeding from a traditional academic career and distant from the ethics of the Basaglian movement; third, a younger generation of people that arrived in Trieste for the legacy of the Basaglian movements and that is generally in charge of experimental services such as the Micro Area Programme; finally, local citizens that are aware of the exceptionality of the Trieste model of care provision.

In this tendency of transition, I analyse the contemporary configuration of the Mental Healthcare System since this is relevant to understand the rationale of the system as such, but I later focus in greater detail on the functioning of the Social Healthcare System in general and on the Micro Area programme in particular. The current economic crisis and the definitive retirement of the traditional leadership of this movement is today the cause of a deep inflection in the movement: at the same time the risk of dismantlement but also the possibility of thickening an urban and distributed logic of care.

Decentralising care

I introduce here a general sketch of the functioning of the mental healthcare system in Trieste as it has developed since the early 1970s and it is working today, to focus afterwards on the recent generalisation of this model in the reform of territorial healthcare services, following this introductory section I will address question such as: how have these critical practices in mental healthcare become the frame for a general reorganisation of healthcare in Trieste in the last decade? What are the limits of this general reorganisation?

Throughout the 1980s and the 1990s the provision of services in mental healthcare has moved from the hospital to the city. Two lines of action can be identified:

1. The first line of action is the one that permitted the institutional practice to be inserted in the complexity of social life: in the Trieste mental healthcare system, the public practices of healthcare provision intervene in the urban space, forcing healthcare professionals to settle in the life of users, to deal with singular forms, limits and possibilities of health and care, and to problematise their own practices in relation to the life of the citizens and generally of the city: this is historically the case of the Mental Health Local Centres, and the development of specific Programmes. Recently the most important example of this logic of healthcare provision can be recognised in the functioning of the Healthcare District - defined by most of the interviewees as the core of the system – and the Micro Area Programme, which consist in a set of activities of integrated care that link healthcare practices with social services and civil

society networks, in deprived urban areas of Trieste, that I widely analyse in the following section.

2. The second line of intervention promoted by the local Healthcare System is the set of devices that intervene from society into the space of health and care. Reinforcing the logic of public health, the Basaglian experiment insists not only on the need of intervening on the social determinants of health but most of all on the necessity of constituting social practices and forms of social life where a different medical practice can happen. According to this logic the Healthcare System supports the Health Budget**,** social benefits directly controlled by the healthcare system; secondly the Local Healthcare System, and especially the Department of Mental Health, has been a crucial actor in the political and legislative development of economically competitive social cooperative enterprises**,** that guaranteed a different practice of social reproduction for the frailest segments of urban population. The deeper analysis of these devices goes beyond the scope of this document.

- Mental Health Local Centres

The local centres for mental health (MHC) have been opened in the late 1970s and early 1980s as always-open services. They are 4, one for each district of the city. They cover the 24 hours and the 365 days of the year, providing support, accompaniment, medical advice as well as shelter and sustainment to users in different moments of their life. MHCs are the core of the mental healthcare support system. They function as the central device of support to the mental healthcare user, in a city where the number of hospital beds for mental healthcare users has been reduced to 8 (from 1300 in 1971) to make contention and detention of users institutionally and administratively increasingly difficult. Biomedical provision of services, medicaments and advice are provided through the MHC.

The activities developed in the MHC have been defined as follows: 24/7 hospitality, day-centre medical visits, home support, individual and family therapeutical activities, group activities, habilitation and prevention, access to social opportunities and rights, housing support, consultancy and advocacy. In order to provide these services, the MHCs serves as a gateway to access the general resources and services of the **Department of Mental Health** (DMH) in general.

- Department of Mental Health

The DMH coordinates activities, defines education programmes, provides protocols of action, but do not relates directly with users if not when contacted through the MHC. Aside the organisation of care in the MHC, the DMH permits to organise a series of “Operative Units” and of “Target Programmes”.

The **Operative Units** include specific services such as the Psychiatric Service of Diagnosis and Care, the only service inside the General Hospital that provides the first entrance to the

system of care in case of abrupt crises, the Service for Residential Support, the Home Habilitation Services**,** among others. The **Programmes of Care** of the DMH instead construct a series of projects and trajectories of support and care for the users. Some can be listed as follow: Educational Grants, District Activities Development (where the Micro Area Programme, analysed in the following section, firstly developed), Family Support, Youngsters groups, Women Support Centre, Minorities and Migration services and so on;

MHCs also involves an approach to the management of care in terms of the involvement of a series of institutional actors, beyond the DMH, as well as cooperative enterprises, social services, public and private enterprises, associations. The MHC construct a care-team, in the term proposed by Annemarie Mol: users, families, psychiatrists, psychiatric nurses, psychologists, educators, accompanists, social services workers as well as different private actors, from professionals to volunteers, to medical and non-medical practitioners, participate in the practice of care.

- Social cooperatives and associations

Since the 1970s, the Department of Mental Healthcare promotes and supports **social cooperatives** organised by workers, users and other citizens. These cooperatives were privileged in the commitment of public services, for their public relevance and function. They were legalised by a national law promoted by Franca Ongaro in the Italian parliament in the late 1980s, for which a cooperative with 30% of workers proceeding from a background of “disability” would enjoy a series of fiscal and legal privileges as well as specific funds.

Contrary to the logic of ergotherapy, the social cooperatives in Trieste involved high-quality production in different fields becoming a significant actor in the local market; cooperatives were organised in fields such as catering, leisure, public services, education, fashion, jewellery and care among others. The principle of the social cooperative organisation has been stated by an interviewee as follows: “doing real things in real places is what is good for your health”. Today the social cooperatives in Trieste act independently from the DMH ad on the market, with a gross product of 15 million euros per year and more than 500 workers. In this dynamic of independent production, the Department of Mental Healthcare economically guarantees bursaries for professional education for around 100 users, during a period of four years (25 appointed grants per year), to guarantee the possibility of an autonomous life of the person beyond the support public services of health.

Associations have also been a crucial actor in guaranteeing an institutional role to a series of actors such as users, workers, family members, volunteers that would not be recognised otherwise. Associations participate in the governance of the general activities of the DMH, in the monitoring of services, and recently the association of users **Articolo 32** is translating the **Peer Support System** of the Northern European Psychiatric Systems (Utrecht in particular) to the open-system of Trieste, with the goal of including a peer-support practice in all the dynamics of the DMH from the first approach of the person with the services and throughout the dynamic of care.

- Laws and protocols

The functioning of the Trieste system has been possible due to the effort of constituting a different regulation system for healthcare. In other words, these practices have become stable protocols of provision and they are legitimated actions through a long-term production of laws, norms, protocols; throughout conflicts, through trials, victories and sentences, as well as through the configuration of a series of administrative practices capable of "managing the institution that we deny". At stake is the possibility of thinking the practice of healthcare and medicine beyond the hospital and in the city; beyond the patient and with the citizen; beyond a vertical transference of knowledge and through the engagement of agents in a collaborative production of care.

Concretely the first milestone of this process has been the approval of the **Law 180/1978** that imposed the gradual closure of all Psychiatric Hospitals in Italy and the development of community systems of mental health support instead. The last Italian Psychiatric Hospital was closed in 1999, but still many facilities and services work according to a logic of institutionalisation; in other cases the deinstitutionalisation has led to a lack of support and services for people with mental health distress. Another significant legislative outcome of this movement has been the definition of the **Law 381/1991** to guarantee a specific status to the entrepreneurial initiatives emerging not only in mental healthcare but from disadvantaged communities in general. With regard to forensic mental health, the Italian parliament has been the first in Europe to approve a **Law 81/2014** to abolish forensic asylums as a result of the pressure from the anti-institutional mobilisation: residencies of care have been opened instead, but yet they remain problematic spaces. Campaigns, on a political, legal and biomedical level have been activated to further regulate the mechanism of mental healthcare in prisons and in criminal justice. On the side of this, a public debate initiated by Franco Rotelli, former Director of the DMH in Trieste, is discussing the opportunity of an emancipatory reform of the 1978 law regime, as well as a campaign led by Giovanna del Giudice is trying to enforce an absolute forbidding of contention as a medical practice, not only in mental healthcare, and on the national level. Other laws and protocols have been activated around general healthcare on the regional basis; I focus on those in the next section of this report.

In 1995, the DMH has approved a **Charter of Users Rights** affirming the need of developing forms of ‘corporate’ regulation that could make explicit and transparent the regime of management and the values of care of each mental healthcare system, in the Italian regional organisation of health.

The DMH is also promoting a series of activities and campaigns at the national and international level for affirming a different logic of care, against the practice of violence in the psychiatric care (contention, electroshock, humiliation, among others), collaborating in the definition of **Green Paper for Mental Health** with the European Commission. DMH is also designated as Collaborator Centre of the **World Health Organisation in Mental Health**. The **World Permanent Conference** for Mental Health, promoted by the DMH, has been

supporting the transformation of regulation, practices and laws in countries like Argentina, China and Ecuador among others.

- Limits and tensions in the Mental Healthcare system today

This complexity of actors and figures allows to organise a mechanism of support and production of care with and around the user; defining resources, roles and dynamics that can accompany the person through the sufferance without constructing a segmented care (during the “crisis” and after the “crisis”), but assuming a continuity of care and a permanent and distributed responsibility around the life of the user. However this practice of care is in permanent danger: a few problems should be mentioned.

The first is the limit of the incident, that is the dissymmetry in the relationship between the institution and the person in distress; a second question emerges in the dismantlement of the Psychiatric Hospital and it is the limit between empowerment and abandonment; third is the problem of management, and the long-term crisis of the radical institution.

1. The problem of the incident, as proposed by Basaglia is a crucial question in the closed institution (the “institution of violence") where the responsibility of the incident is reversed upon the abnormality of the patient. The possibility of freedom stands only on the limit of the incident, where "the choice of death, as refusal of a unlivable life, as a protest against the objectivation that affects one’s own body, as the only possible illusion of freedom, as the only possible project” are the only agency recognised to the patient. Opening the institution involves taking a collective responsibility of the terms of antagonism that the moment of freedom involves. It is not about the doctor becoming the saviour of the patient. In order to avoid the asylum to become "a garden of grateful servants” (UR p 25), the limit of antagonism must be inhabited. The dissymmetry of power in the relations has to be affirmed rather than hidden, since the tensions of care, the limit of the incident, the difficulty of dialogue, are elements that always intervene in the mental healthcare process

2. After the opening of the institution the development of services in the everyday life of the city has become a crucial field where to challenge the limit between freedom and empowerment, avoiding a logic of abandonment or a mechanism of control. In the words of Franco Rotelli, the choice has been to implement services rooted in the social networks of the city; connected to other institutional instances as well as with social and private actors. On the one hand this has permitted avoiding a neoliberalisation of mental healthcare services (a privatisation of care for the rich, and misery and abandonment for the poor in the critique of Basaglia of the 1963 US Community Mental Health Act, also known as Kennedy Act). However this decision was controversial in the 1970s and the 1980s, especially from the point of view of anti-psychiatrist like Roland Laing that sustained the services would finally stigmatise, separate and control users in their everyday life in the city. This is still one of the crucial problems of the DMH today.

3. The third question, which relevance is emerging in the last few years, is the durability of this institutional arrangement. The question of care is both an ethical and a technical question. The limit between empowerment and control is at the same time, determined by the culture of care in the institution. i.e. the values and practices of the workers, and also by the resources that can be mobilised to provide full care to the person in distress and a continuity of attention. It is not enough the transference of singular and individual knowledges to guarantee the continuity of this model. It is indeed a technical and institutional question because the possibility of disarticulating the moments of tension and incident depend on the ability of opening new lines of interlocution in the moment of sufferance and distrust. On the one hand, the crucial problem is how to skill the workers and how to contest the conservative psychiatric culture of the Faculties of Medicine still today, and secondly how to establish mechanisms to monitor the everyday practice of the institutions. On the other hand, the institutional instability and fragility is not only cultural but managerial, where the problem is not only, although crucially, the reduction of budgets, but also the limitation and protocoling of practices as a mechanism of control and normalisation. In the logic of austerity, the problems is not only cuts, but also the repression of institutional imagination.

Micro-Area Programme: gateway to an ecology of care

The social healthcare system

Social-Healthcare District

Since 1971, the prerogative of the Basaglian practice has been to constitute a service around the user, a principle that has been transferred in the last decades from mental healthcare to the general management of the politics of care in Trieste and the Friuli Venezia Giulia Region, in the frame of Italian National Healthcare System[2].

The first step of this translation has been in the early 2000s when Franco Rotelli became the Director of the Social Healthcare System of Trieste (SHS). It consisted in the institution of the Social-Healthcare District (SHD), and importantly in the relocation to the districts of doctors, nurses and administrative staff of the DMH (and through the involvement of cooperatives and associations in the local healthcare system), in the attempt of translating the ethics and protocols of the Basaglia system in the SHS of Trieste.

[2] In Italy, healthcare is a universalistic non-selective system, provided to all citizens and residents by a mixed public-private system. Undocumented migrants are guaranteed free access to the national health service. The national health service, Sistema sanitario nazionale, is organized under the Ministry of Health and is administered on a regional basis. Although different in each region, the system is defined through a general separation of: family doctors, which are entirely paid by the national system but are private contractors; national system hospitals (as well as city-owned and private-conventional ones, mainly managed by companies controlled by the Roman Catholic Church) that cover specialistic care; Social Health Services that are in charge of prevention, public health, rehabilitation and other services to the person in need. Users co-pay part of the service as well as prescription drugs according to their income; a series of chronic, rare and disabling diseases are completely free for every person. Each region can improve the guarantees to the citizens. Users can access to the services in all the country.

The institution of the local districts should be seen as the main infrastructural element for the implementation of a continuity of care capable of supporting the health of and caring for urban dwellers beyond the hospital, in the everyday life of the city: the constitutively difficult freedom of urban life. The organisation of the district can be defined as a matrix of different vectors and interventions on populations of approximately 50.000 inhabitants.

The SHD occupies an unusual space in the configuration of the healthcare system in Italy: it reverses the logic of the institution and following a regulative system similar to the personalised care system of the British National Healthcare System; it affirms a systematic centrality of regional and city-council actors in the management of care, as well as it aims to involve social and non-profit actors in the practice of care.

The actions of the SHD can be categorised as follows:

De-Institutionalisation of care: The most of the hospital specialistic competences are distributed in the space of the district system:

- Day hospital and home visiting for posttraumatic care; chronic disease attention; neurodegenerative disease support.
- Activation of local services of specialistic care: such as rehabilitation, assistance and care, controls and monitoring
- Care projects addressing specific groups such as women, migrants, children, elderly people, differently functional people, mental healthcare user and so on.

Coordination with Welfare*:* The District can coordinate the healthcare interventions with the social services, the Public Housing Company and other services of welfare. This is specifically developed in the Micro Area Programme (below), but introduced as a general goal of the System. This can allow:

- Activation and reorganisation in the provision of economic and social benefits,
- Access to social rights in accordance to the specific conditions of the citizen.

Public Health*:* The specific agencies for Public Health of the Social Healthcare System are reorganised in order to deal with the specific contexts in which they intervene:

- Inspections and development of labour rights and security controls
- Development of support, attention and care for legal and illegal drug addictions
- Mental healthcare services, as explained above.

General practitioners*:* The Italian system of general practitioners, organised on an individual engagement of “Family” doctors with the patient, is linked back to the District professionals through the production of networks, transversal activation of resources etc.

Regional Law of Healthcare Reform 17/2014

A new Regional Law for the Reform of the Healthcare System has been approved in November 2014. It includes the integration of the three parts of the Regional Health System under the same direction: the Hospital, the Medicine Faculties and the Social Healthcare

System, in the name of a reorganisation of healthcare services as a complex and articulated response to the specific needs of single users.

The rationale of the law is that of organising a system of competences and human resources, a series of protocols and facilities, as well as an administrative articulation of budgets capable of implementing the Basaglian rationale of governance in the general system of regional healthcare, namely the democratisation of medical knowledge through the reform of faculty education, the deinstitutionalisation of medical practice through the deinstitutionalisation of specialistic care, and, in the SHS, the further subjectivation of workers and users as active citizens in the provision of public services (through the provision of resources and an institutional infrastructure capable of mobilising them). The law aims to provide users with information and tools regarding their practices of care, to disarticulate the hospital as the administrative and economic centre of the healthcare system, and to integrate the education system (both in terms of medical education and public health programmes) in the functioning of the healthcare practices.

Some crucial elements have been defined in the law, although the realisation of protocols for its application have determined contrasts among different economic and professional interests:

- Territorialisation of education and link between the university and the communities (beyond the hospital)
- Definition of accountability and informative protocols for the provision of pharmaceutical pills, and the institution of monitoring bodies
- Institution of institutional bodies to guarantee user rights in their relationship with the healthcare system
- the reorganisation of budget portions to guarantee an equitative distribution of resources beyond the hospital in the territory
- The reorganisation of budget chapters to permit a different use of resources
- The creation of multi-professional and teamwork goals for the practice of care that aim to integrate social and medical knowledges, resources and practices in the urban politics of care.

This definition of new normative protocols faces partial interests of different lobbies inside the hospital and in the private market, but also needs to engage into a technical beate about the efficiency of a new model of access to health and care constructed around the social complexity of life and around the singular needs and desires of users and social groups. I focus on these attacks tensions and mechanisms of regulation in the last part of this chapter.

Micro-Area programme

The programme: goals, principles and practices

The Micro-Area (MA) Programme consists in a set of activities of integrated care that link healthcare practices with social services and civil society networks, in deprived urban areas of Trieste with populations ranging from 800 to 2500 people for each area. Enquiring these integrated policies allows for in-depth analysis of how welfare transition in healthcare

activates mechanisms of transversal governance at the urban level, capable of intervening on the social determinants of health. The MA programme has been promoted as pilot programme “WIN Micro-Area” in 2006, following the programme Habitat by the Social and Healthcare System of Trieste with the support of the World Health Organisation of the United Nations and in collaboration with the Local Council of Trieste and the Public Housing Company of Friuli Venezia Giulia.

The programme aims to reinforce social cohesion in accordance with the principles of health and care policies approved by European Council of Lisbon in March of 2000 and with Agenda for Social Policies of the European Commission of February 2005, and to develop mechanisms of Welfare Innovation (WIN) at the regional level. MA programme counts today with 12 sites in Trieste and 15 sites in the whole of the Region, with an incidence on the most vulnerable 10% population of the city (20.000 people). The MA facilities are usually one or two ground-level apartments provided by the Public Housing Company: one specifically focusing on the healthcare services, and the other on developing a direct and permanent presence of City Council services and of the Public Housing Company in the site.

The programme involves a Coordinator of each Micro-Area (MA) and a equipe coordinating MAs at the city level. Each full-time Coordinator (MAC)[3] links its practice with the relevant SHD and coordinates with other MAs of the same district on a weekly basis. The MAC also works in collaboration with two part-time “Social Concierges” for the Micro-Area: one proceeding from the social services of the City Council, and one from the Public Housing Company.

The City Council social concierge is in charge of coordinating a series of activities of socialisation in the Micro-Area as well as supporting MA inhabitants in all the administrative relations they have with the city council (not only regarding social services, but all the services provided by the municipality). The Public Housing Company Social Concierge is in charge of activating resources for the management of the communal areas of the MA and can be involved as mediator in local conflicts.

MAC and the SCs collaborate with a series of public-private actors of care in the specific site, like social groups, private companies, volunteer associations, local private or public-private services of care, political and social actors and centres, and obviously with the District Healthcare Services described above. At the city level they collaborate not only with the Hospital and the general Healthcare system, the City Council Social and Cultural Agency

[3] The role of the MAC is not prescribed through a series of limits and duties, through which the citizen is included as the objective recipient of resources, attentions, benefits. On the contrary, the singular story constitutes itself as the space of intervention - it could be a woman recovering from some medical intervention and living alone; she cannot walk properly, but does not want to stay in a rehabilitation house during that period. So the worker starts to imagine a series of resources that can be activated in response to the situation, through the public and social networks of the welfare state and the public institutions, as well as through the business and social network of the neighbourhood. The MAC calls the social services of home support and activates the "solidarity service", the network of local business, the vegetable garden in her block, so that they will check on her. At the same time, the worker takes care of mediating with the Rehabilitation Service and of translating the professional practice of medical care in the complexity of the everyday life of the citizen.

and the Public Housing Companies that promote the programme, but also with a series of social cooperative enterprises, as well as other entities and private-social actors, in the field of care, culture, and social cohesion.

The total cost of the Micro-Area Programme is estimated between 100.000 and 200.000 euros per year per site, counting the people dedicated to this programme, the facilities at disposal and the resources that are used in the programme itself.

The practice of MA can be catalogued as a practice of care that moves the threshold of the public services on the doormat of the frailest users. In the intention of the programme the complex life of the users becomes the site of a medical practice that has to be permanently present. It is based on a lateral and transversal conception of services that links different practices in order to respond to the contingency, needs and desires of the user, as well as with the social and collective needs of a community and of specific groups. The aim of the programme is to reverse the relationship between users and services, de-institutionalising the mechanism of urban welfare and empowering the users in the management of facilities and resources.

The institutional goals of the MA programme have been listed as follows in the SHS protocols:

1. Sharing knowledge on public health and bio-medical condition of the each MA with the inhabitants of the site
2. Developing services and allocating resources to contrast the institutionalisation of care (personalised and home care)
3. Monitoring the proportionate and appropriate use of pharmaceutical goods
4. Monitoring the proportionate and appropriate use of diagnosis
5. Monitoring the proportionate and appropriate use of therapies (care and rehabilitation)
6. Sustaining and encouraging local networks of mutual support in the community
7. Promoting the collaboration of healthcare and social services with associations, nonprofit and profit actors to improve local well-being
8. Promoting an integrated functioning of different public and social services acting in relation to the same individual, family or social group
9. Promoting equity in the access to resources, services and facilities, with regard to the frailest segments of the population.
10. Developing the quality of life (activity and autonomy) for the frailest population in the site.

In recent years the Micro Area Programme coordination promoted a series of researches on the functioning and the results of the programme, as well as training activities for the actors involved in the programme throughout the years. Particularly relevant have been a series of seminars in the University of Trieste coordinated by ENAIP to analyse the impact of these services on the hospitalisation rates of the MA sites in comparison with richer neighbourhoods, positively affected by the facilitation and guarantee of a wider access to social services and healthcare district facilities.

A significant project of research has been the one conducted by the anthropologist and psychologist Giovanna Gallio: a project of qualitative oral history inscribed in the stream of narrative medicine that served as ground for the development of a series of seminars and professional training with the workers of the whole SHD aimed to develop the involvement of all the different equips of the Social Healthcare System in supporting and reinforcing the activities of the Micro Area programme.

The second publication coming out of this series of workshops is a significant ground to analyse the operative principles, the *ethics*, of the Micro Area Programme as an institutional device embedded in the limits of the neoliberal precarisation of care, but also in the possibilities opened by the cracking-up of the prescriptive social-democratic regime of welfare. In the general frame of a neoliberal deregulation of care, in the crisis of public services vertical provision and in the growing relevance of a conception of welfare as social networked coproduction of care, some principles can be outlined:

- **Integral Welfare:** In Franco Rotelli's view, the possibility is that of understanding the role of institutional practice as one that operates as "bench done of snow": the role of institutional practices is that of supporting and guaranteeing the social reproduction of society, the difficult freedom of social life, not that of reproducing the institution itself. Franco Rotelli argues, the institution should provide the users with resources and supports in the moment of frailty, *in the winter of their life*: a bench, done of snow, where to sit and rest, to start again; the snow will melt in the spring of life again, when the user will stand and live autonomously. The institution will be then left "empty". Rather than a problem, this will be an opportunity for the institution to reinvent itself, its practices and its protocols.

  The radical understanding of institutional practice in the Rotellian - if such a term can be coined - relies on the same imagination of community welfare as a step both beyond the idea of an prescriptive and paternalistic practice of welfare state - the Social State - and beyond an entrepreneurial conception of social policies - the *Animateuring* State. However the Trieste experience differs on a significant element, contesting the centrality of the community as identitarian limitation that defines the constituency to which the health and care system should refer. In the MA and the SHD - as core devices in the SHS and generally in the healthcare system of Trieste - the centre of a different understanding of welfare stands upon the following ground: shifting the focus of public services from "guaranteeing and disciplining social production" to "sustain and empower social reproduction".

- **Social empowerment:** Franco Rotelli reclaims the legacy of the Basaglian practices and affirms that deinstitutionalisation is not only the disarticulation of the institutional site of care (where the disciplining and controlling actions are *embedded* in public care), but also and significantly a practice of social empowerment through the public investment of economic, human and symbolic resources in the development, reinforcement and empowered of territory-led micro-systems of care. Inventing an institution means producing commons in order to sustain the autonomy of social reproduction - putting into crisis the principle of internal reproduction of the institution

and facilitating those instruments to allow society to challenge institutions and who manages them.

"The production of life and social reproduction are the practice of the invented institution, they have to avoid the narrow path of the clinic gaze, of the psychological investigation, and of the phenomenological comprehension, and become fabric, engineering, capable of rebuilding sense, producing value and time, taking charge, identifying situations of sufferance and oppression, re-entering in the social body, in consume and production, in exchange, new roles, new material modes of being with the other, in the gaze of the other." (Franco Rotelli, L'istituzione inventata, my translation)

- **Continuity of care:** As Giovanna Gallio proposes in her work, in order to address this transformation of the logic, and this transition in the practices, of the institution, the system of Trieste and specifically the MA aims to develop a continuity of care from the hospital to the complex ecosystem of social life, which should lead to the configuration of a *social city that actively heals* and to the reorganisation of the urban model of care as a composition of micro devices than can intertwine different resources, precipitating the practice of care from the institution into the specific context of each user or group.

  The articulation of the biomedical intervention in the complexity of social life is particularly important when the European public health is increasingly marked by population ageing and chronic diseases. The practice of Trieste develops a presence in the urban life and everyday life of the citizen, rather than reinforce a clinical and pharmaceutical chronicity. The practice of care is permanent instead of chronic, constituted through the material integration of the biomedical practices, social services and the subjective interventions in the life of the city and of the citizens. The micro-areas programme is the first device in the Trieste general healthcare system that transfers the responsibility of "welfare" in the real life of the people, activating the social services of the state, writing the adequate and innovative administrative protocols, organising social and private resources, not in a predictive and top-down mode but around the specific needs of the person or of specific segments of the population.

- **Networks and informal resources:** The possibility of a continuous care rests upon a critical engagement with a fluid machine - a liquid welfare, to gently mock the over-used expression of Zygmunt Bauman - that involves an articulation of formal and informal resources; public, social and private actors; human, symbolic and social capital; monetary and nonmonetary circuits. In this context, the line becomes very thin, between a mechanism of social empowerment that reinforce the claim before the state for its responsibility over the fragility of social dynamics in the crisis, and on the opposite a neoliberal mechanism of delegation onto community self-organisation that covers the gaps left by the withdrawal of the state.

In the practice of Trieste, the question of this fluid machine is addressed according to principles that contrast a neoliberal understanding of welfare. If on the one hand the practice of deinstitutionalisation has always been on the same page of both a liberal and a libertarian understanding of care and the state (i.e. the Kennedy act, but also the anti-psychiatric British movements among others), this practice in Trieste is radically linked a) to a permanent mobilisation of resources from the State to society, through dispositives such as cooperatives, associations and users-led laboratories, as well as through individual and family mechanisms of economic support that reinforce the autonomy of the user; and b) to a permanent deinstitutionalisation of knowledge, configuring institutional and non-institutional sites where the expertise of medical practices, or the management and economic limitations of the institutional possibilities are made explicit, discussed and in cases contested in the public debate among the workers, with the inhabitants and in the local medias.

- **Training and education:** One of the crucial problems of the Basaglian approach to mental healthcare and generally the critique of biomedical practice rests upon the question of a dissymmetry of knowledge between the different actors involved in the cycle of caring. The possibility of an deinstitutionalisation that is not the creation of a "garden of grateful servants" rests upon the possibility of engaging into a process of emancipation for all the parts involved in the project of care, dealing with the double objectivation of biomedical knowledge: on one side, the body of the patient as passive object in the intervention of medical practice; on the other side, the technician as material mediation between the scientific knowledge and the body on which the procedure has to be transferred.

  The MA dispositives emerge as a site where the disease is inserted in social life, where the patient is not lying on a bed, but acting in a community. The possibility of continuous practice of care that involves informal networks in the management of health is possible only if training and education become a transversal practice for the workers not only in the MA but in all the SHS of Trieste, and at the other hand not only for the direct users of services but for the general community involved in the microarea. This practice of commoning, from the medical and the administrative towards the life of the community (an expertise not only on the diseases, but also on the services, resources and facilities that the MA can activate), encounters the horizontal knowledges of each specific site. In the emergence of a medical landscape of perdurant pathologies, the possibility is that of disarticulating a 'chronic' approach towards the patient that is admitted or discharged from the medical services, towards a permanent presence of services as possibility at reach for the users, in her quotidian life.

During my research, after desk research and after 15 individual qualitative interviews with relevant actors, I have been doing fieldwork in two different micro-areas, Zindis and Ponziana, two weeks per site. In Zindis I have been participating in the organisation of cultural activities for the youngsters in the neighbourhood, as well as participating in social activities of the Micro Area centre; in Ponziana I have been accompanying the MAC in home visiting and support, as well as in her work with other public and private actors involved in

the team-care of the MA. Apart from desk research, interviews and fieldwork, I have been participating in public seminars and debates on the Micro Area Programme and I have been organising two research workshops with the coordinators of the Micro Areas of Trieste, supported with the construction of a website of audio research (www.microraree.wordpress.com).

The development of a mixed-methodology research based on ethnography and co-research, together with qualitative interviews and desk research allowed me to tangle the practices and conceptual grounds of the Micro Area Programme in dialectical and collective way, allowing to transfer questions from the abstract to the concrete, but also among the different layers of the system of social and healthcare services.

The famous statement of Donna Haraway “stay with the trouble” sounds here as one of the most precise way of referring to the complex practice and the conceptual contradictions involved in the everyday life of these devices and services. For this reason I propose here a categorization of the practices, based on research and ethnography, and a set of questions, tensions and contradictions that emerge in the everyday life of the services and that have been discussed with the workers of the MA during the internal seminars I organised. It is important to stress the significance of Donna Haraway’s methodological statement as part of a longer tradition and broader debate about the practice of critique and here significantly of institutional critique. I intended my discussions with workers and users and my participation in the everyday life of the MA as part of a collective analysis that the space of my research, my questions, my point of view allowed to open. In this sense, a loyalty to the grounds of the debate, the privacy and the omissis requested by any of the actors mark my report and also define the priority I give here to specific practices and specific issues, problems or tensions, because these are relevant not only to the analysis but also to the possibility of improving the functioning of this systems of practices.

In my research I identified four levels of interventions and practice. *In italic I propose examples to understand how the different levels work and to identify the limits they inhabit. I also compare elements emerging from the practices of different MAs to show how a singular practice cannot be recognised as the solution, but a serie of possibilities can be explored.*

Contact: The first is a level of contact of the MAs with their population. According to my interviews, the MAC has a direct contact with at least the 50% of the MA population; a contact that can be formed in different ways depending on the specific site. This contact can be passive, through the material presence of the MA, the public activities and advertisement; or it can be active, guaranteeing a continuity of care for those persons that have a specific vulnerability.

Contacting is one of the first sites where the limit between user and producer of the MA blurs. In Zindis, the MA has developed a protocol for volunteer collaboration with two elder women. In their daily walk and in accordance with the MA worker, they take the responsibility of contacting particular users with whom they have a specific relation of trust. In Ponziana, the logic of contacting has been constructed to disarticulate rumourologies and involve

people in a different logic of care, both by using social lunches as a place to share informations, and also allowing the coordination of home visits among different services (rehabilitation, chronic disease, social services, and so on) to check-in with users in charge to other departments.

Systems A second level of contact and health monitoring is achieved through specific activities with specific groups, such as social lunches for specific patients; support activities for families and individuals; food banks and time banks for the local community; a series of social and public health activities, as well as through home visiting. All this activities serve also for activating users, establishing and maintaining a relationship with public services – and allowing the reorganisation of a series of medical practice in a non-institutional environment. This involve the definition of mechanisms of participation of users in the management of the facilities, activities and resources of the MA, and the definition of new local practices of the MA programme in each site.

A significant system is the one constructed around food and health. This is an issue present in all MA and yet its management is different in each of them and permits to understand the complexity of instruments and alliances that the MA can build. Many of the MA organise social lunches: a debate emerges among the MAC if this can be everyday, if it should be targeting specific groups; what kind of diet should be provided. In Zindis lunches are every second or third day and serve both to guarantee access to healthy food to a specific target, but also to coordinate the active citizens of the MA. In Ponziana, lunches serve to maintain community links in specific groups, especially among people with chronic diseases. In Campi Elisi, lunches serve as gateway to other health services, since doctors and nurses of the hospital are decentralised to the MA in the afternoon after the social lunch. On another level, in most of the MA is not only active the EU Food Bank (carbohydrates and proteins), but also a agreement of collection and distribution has been achieved with the General Market. This provides the vegetables and fruits for the social lunches, but also permits to make boxes of vegetables for people in need. MA also develop collective vegetables gardens in the sites.

Bottom-up Advocacy: Another function of the MA programme is to activate a series of resources and skills for the user in the public system as well as through private and social networks. This can involve the people in direct contact with the MAC, SCs and the MA centre, normally counting for a 10% of the MA population. The MAC proposes a series of services, tools and possibilities, that the user has the right to claim, both through public and private programmes; the MAC also activates the relevant connections and information flows between one service and another, and between the public instance and the citizen.

In the mechanisms of advocacy a series of tensions appear: the one between privacy and public services and more generally, the dissymmetry of power involved in the processes of care. In one MA, I have been assisted in the management of complex situations where the bio, social and psi elements of care were intertwining constantly. The space of trust constructed in the everyday life of the MA permitted to unfold and analyse not only the configuration of the problem but also possible lines of escape. On the other hand, the same

ground of trust moves the workers beyond the limits of competence and into the field of responsibility. The practice of MAC can be compared to that of a legal or NGO clinic in the anglo-saxon context. Concretely in one case, in a situation of domestic violence and medical fragility, the MAC agreed on an informal road-map of management with the user which involved not only a specific way of dealing with her flatmate, in this case her son; but also how to deal with police in order to avoid tensing the relationship any further; how to deal with the elder residence that would take care of her; how to deal with public housing company. In other words the MAC role is both to negotiate a route with the user, to advocate for rights, resources and services in a system of scarcity, and also mediate with other institutions and actors on the limit between competence and responsibility, to define new protocols to support the difficult life of the user.

Project. Another role the MA program develops is the design and activation of specific projects of care around personal needs or target groups. In the first case, it can refer to a project to respond to the needs around a specific user or family to cope with a difficult situation in terms of health and social well-being (ranging from domestic violence, youth problems, chronic disease, drug addictions, mental healthcare issues). Secondly the design of a project can address specific groups and involve a series of public, private and social actors in the definition of a common programme of action in the site. In both advocacy and project design, the MAC acts on the margin of the welfare system, not including the user in a prefigured scheme of welfare management, but assuming the responsibility of researching the resources that can be activated, as well as supporting the user in claiming and obtaining the support of the welfare state.

The capacity of the MA of being in the territory, and therefore engaging in its contradictions, activating systems and advocating for resources permits the MA to intervene in propositive ways that are pertinent to the space. In a few cases, the MA have been activating mechanism of housing interchanges and house sharing to respond to specific and compatible needs of the users. In one case, for example, a growing family living in a small apartment on the ground floor was able to interchange its apartment with an elder person with mobility issues living in a flat without elevator. In another occasion, the possibility was that of moving four elder people in need of permanent care into a cluster of three apartments in the same block where they have been living for a long time, sharing the cost of permanent care. Not only the MAC has been able to identify and match specific needs and desires that would have been invisible to other services, but also it has been necessary to develop a protocol of agreement with the public housing company to develop practices that did not exist before.

Attacks, limits and tensions

The neoliberal critique: measure and accountancy

The dynamics of neoliberal governance have been continuously acting, trying to limit, boycott and sabotage this system of care. The Basaglian project has been subject to many penal and civil trials throughout the last four decades and, as explained above, one of the issues at stake has always been the production of jurisprudence to sustain the process.

The neoliberal critique of the Trieste model is sustained by three social and economic forces, that are right-wing political parties and professional lobbies supporting pharmaceutical corporative interests and professional privileges, as well as part of the Church, the one that has economic interests in the management of healthcare. These actors are not only expressing a conservative practice, that is the reproduction of a system of care that allows a hierarchy of powers, but are positively (in the 'philosophical' sense) affirming a project of care based on the market-management of scarcity and on an individualised conception of service provision. This positive tension aims to restore an architecture of care based on specialistic diagnosis and prognosis, pharmacologist medicalisation and private structures, once the patient abandons the public hospital. It is a model based on an objectivation of the patient, on the privatisation of care (that is the privation of care for the poor), and an economic and cultural hegemony of conservative infrastructures in the management of care. The discursive and practical conflicts raised by neoliberal critique on the SHS/MA system can be listed around two fundamental and relevant problems:

Measure: How to demonstrate the effect of the MA on the health of a neighbourhood? Significant problems rise indeed in the attempt of defining mechanisms to gather data and measure the effectiveness of the MA interventions on the social determinants of health. The definition of quantitative indicators to reflect the activities of MA indeed is difficult: a relevant attempt has been that of measuring the effect of MA on the hospitalisation rates of specific neighbourhood, in comparison to the evolution of richer neighbourhood where the rates were lower. If the rates have been converging towards the average level of the city in the late 2000s after the activation of the MA, recently datas have been diverging again, due to the effects of the crisis but also and significantly to the modification of internal protocols in the SHS where, after the retirement of Franco Rotelli. Another significant data has been the improved equality in the distribution of resources at the city level, i.e. the access of the poorest to an increasing amount of resources.

Accountancy: Problems have been raised referring to the accountancy of the economic activities in the MA. One of the crucial effects of the MA is that resources can be allocated in accordance to pertinent criteria, allowing to activate the different institutional bodies in order to use the more appropriate and competitive resources for each situation - for example in the management of home-care, rehabilitation where the possibility of activating non-healthcare resources to support some users allows a significant economic advantage. The MA programme has also activated and monetised a series of formal and informal networks of the area. However this model of action interferes with the managerial infrastructure of the healthcare system, forcing it beyond the predetermined chapters of the budget. When the MA calls for the organisation of transversal operations, for the mobilisation of interdepartmental resources, for the investment in inter-institutional facilities, or for the coordination of different tasks from workers of different areas, the system reaches its limit. The problem of accountancy is therefore a crucial site of attack: many actions of the MA are driven through non-appropriate budget chapters. The possibilities provided by the new regional law, 17/2014 which defines the provision of wider budget to community healthcare, still need to be protocolised in technical terms allowing the creation of common budget

shared by the different institutional bodies, something that would allow to set the ground for transversal accountancy practice in the institution.

The social democratic critique: universal vs singular, freedom vs control.

Another series of problems emerge however confronting this system of care with a traditional left understanding of healthcare, based on a universal conception of care. The first point of conflict is between a conception of **universal** care as universalised and disciplined provision of services and a practice of care based on singularities and open-access as a complex and ambivalent challenge to the homogeneous, prescriptive and enlightened understanding of the medical practice and welfare in general. In the literal tension between health and care, the imagination of a different welfare enacted in Trieste rests upon a complex and articulated understanding of these two words: on a critical approach to the biological, social and cultural understanding of what is health and illness, but also on a complex understanding of care as an assemblage of different practices, actors, memories and material possibilities.

This raises the second question of the social-democratic critique of this system of care that importantly signals the risking limits, firsty, between individual freedom and **control**, but also an on the opposite end of the spectrum, between knowledge and equality. These limits have been historically managed through a legalisation of procedures and protocols and this jurisprudential production must be part of the picture, but, as it emerges clearly in Trieste, this is not enough. The tension is one between the institution and the citizen.

At stake in the Trieste politics of care is the attempt of making the citizen aware and decisive in the organisation of services. This is done through the production of a service of integrated care that breaks the separation among competences and puts the responsibility at the centre of the “duty” of care, taking the threshold of the services closer and closer to the citizen, even by putting at risk the stability of the institutional protocols, in a permanent attempt both of empowering the people in producing new institutions and of pushing the institution to unlearn its own practice and de-reinstitute itself everyday.

As I argued elsewhere, “in the [MA] the role of the public worker is not prescribed through a series of limits and duties, through which the citizen is included: as part of the state, as the objective recipient of resources, attentions, benefits. On the contrary, the singular story constructs itself as a narrative, constitutes itself as a space - *it could be* a woman recovering from some medical intervention and living alone; she cannot walk properly, but does not want to stay in a rehabilitation house during that period. So the worker starts to imagine a series of resources that can be activated in response to the situation, through the public and social networks of the welfare state and the public institutions, as well as through the business and social network of the city. In order to do this, she has to deal with a series of tiers and protocols, permits and hierarchies, logics and values, and find her way through different agents, allies, tools.”

“In other words the production of provision happens on this threshold, as a device that destitutes and institutes a practice. In the Microarea "the threshold does not exist: the service is there, the space is there to be inhabited". The limit of the state is contested in a

concrete way, through the production of thresholds of invasion that instead of individualising the citizen in relation to the state, constitute a collective ethos made of responsibility, reciprocity, inclusiveness.”

On the limit of a crisis, today.

Along these threshold, some critical tensions of the MA can be investigated, both to challenge the neoliberal claim of efficiency - where the patient is an individual set of datas to be managed through measure and accountancy - and the prescriptive welfare state - where the citizen is a recipient of rights, part of the state. Empowerment, responsibility, autonomy, equality: these are the “tensions in practice” that emerged in the concrete practice of service provision, where contradictions explode and problems can be tangled.

In this stage of my research, I developed a series of workshops to discuss about the tensions and contradictions of MA with the workers. The intention, following the debates of militant research, was that of avoiding an objectifying practice of knowledge production: on the one hand, avoiding to reduce the voice of the MA users and workers to native informants, providing analytical instruments to make them co-researchers; on the other hand, the practice of militant research, contrary to participatory action research or participatory observation, is not looking for a neutral positionality that describes and prescribes, but for an active involvement in the process, where critique and practice participate in a collective project.

The objective of the workshops was contributing to the MA workers project to constitute themselves as a collective of study and research around welfare, the crisis and the practice of community care. In the first place my contribution was that of collecting a series of stories and voices of the objects that animate the MA, as collectively agreed in a first workshop of co-research; the decision to focus on objects, following the boundary objects approach proposed by Susan Leigh Star, intended to avoid an individualisation of narratives and to open a dialogue among the workers. In the second session, these set of voices, that will be soon published online, served as sparks to identify and discuss tensions and contradictions. They will serve also for two collective discussions in October, one internal and one in dialogue with analogous practices of community healthcare in Madrid and Thessaloniki with the participation of Marta Malo and Marta Perez.

The discussion started around the following dichotomy: is the MA programme providing a mechanism for community building or is it building community to constitute a gateway for the community healthcare services? The responses were diverse but yet consistent one with each other, both affirming the specificity of each site, and identifying common problems: the differences between the institutional, urban, technical and social configuration of each site emerged.

Depending on the specific arrangement of MA governance - the protocols of agreement between the SHS, the local council and the public housing company - the activities of the MA would focus on different issues and through different practices. Moreover, the positionality of the MAs practices (in the wide spectrum between socialisation and health) would also deeply

depend on the knowledges, skills and backgrounds of the workers and volunteers involved in the management of the MA as well as on the social configuration of the neighbourhood, in terms of problems, needs or desires, but also in relation to the community resources activated through the MA.

This multiplicity of configurations converged in recognising the threshold between socialisation and health as the site where *care* becomes an uncertain practice. On this threshold of care, a series of transversal tensions can help to interpret the MA, not as a device to be described and prescribed, but as a device that reads and participates in a social reality.

The space of tension between socialisation and health is a threshold between individuality and the state. First, the question is how to avoid **empowerment** becoming a practice of deregulation of rights; second, how to promote a subjectivation of the public workers not as objectified carrier of competence but as **responsible** actor of a community; third, how such responsibility do not become a paternalistic practice that deny the **autonomy** of society; finally how to perform a possibility of **equality** through the distribution of knowledge in the practices of care. These fundamental lines can be expanded as follows:

- If MA participates in providing skills and tools for the **empowerment** of the community in the management of care beyond the provision of public services (for example activating specific groups of care in the community). This tension of empowerment participates in the same line of deregulation of welfare of the “Big society” in the United Kingdom. Whilst reforms like the UK Big Society sought simply to transfer responsibility for service provision from the public sector to society, with very little success, healthcare policymaking in Trieste are not only transferring responsibility but also resources to these social management of care, both through the bottom-up activation of resources (in what I have defined the advocacy function of social workers in the MA) and through the co-design of local projects of care (for example providing grants and resources for the community, managing social activities, constituting cooperatives etcetera).

- This practice of empowerment as mobilisation of resources that contrast welfare-state-withdrawal implies a problematisation of the limit between competences, in accordance to its institutional mandate, and **responsibility**, in relation to the community problems and resources: a tension between protocols and norms defined in accordance to an institutional logic, and the need of providing a concrete response to specific and articulated problems. Through advocacy and project design, it emerges clearly how the norms and protocols of the welfare state often limit the capacity to deal with the contradictions and ambivalences of specific configurations of fragility. The MA workers face everyday the need of breaking apart protocols and norms to allow the frailest population to access facilities, resources and services, stepping beyond the threshold of imposed protocols in order to build a relationship of trust and support with the person in need. This practice of civil disobedience has been part of the Basaglian movements since the early 1970s. The question is how to make this practice of responsibility a) a collective one and b) a

instituent practice, a practice that configure a new jurisprudence, new protocols for services provisions and new rights that users can claim legitimately in front of the state[4].

- The presence of welfare in social life inhabits a dangerous limit: the one that transforms the responsibility of care into a paternalistic practice of control and in a denial of **autonomy**. In order to avoid this limit becoming a moral matter about what is a good (or bad) public worker, this threshold must be problematised in institutional terms, contesting an interpretation of autonomy as individual practice of choice, and affirming the institutional practice of care as one where a constellation of actors participate. This displacement of autonomy happens by acknowledging and challenging the dissymmetry of powers, knowledges and emotions involved in the assemblage of care involves, where the practice of healing, around the singularities of those in distress and need is assembled in the interdependence between (bio, psy, social, cultural, economic and political) dynamics and different (intimate, social, economic, cultural institutional) actors in a complex system.

- The possibility of constituting a social autonomy of care based on public responsibility and social empowerment - that is a system in which a) public workers participate in accordance to a responsibility towards society, and b) the community has the public resources to take care of itself - profoundly depend on the distribution of knowledge, on **equality** as a material assemblage of agents. The relevance of knowledge as a relation of power is particularly relevant in the biomedical practice, although it is relevant in the main spheres of encounter between society and policies. The practice of study is emerging as a collective need among the MA workers, not only as a practice of education to learn, but especially as tool of research to understand the logics that configure reality, the constellation of forces that compose the real. This attempt needs to become a collective and transversal practice both in the institution and in the site, to involve the territory and make the MA a device of perception and composition of care in the city, a device that support the urban social production of care.

As mentioned earlier in this text, the radical process of care that I have described above has gone through phases of profound crisis, as well as through moments of weakness. Austerity is the frame of crisis in this moment: the limitation of economic resources affects the possibility of care-teamwork and also it has a great impact on the possibility of developing specific and experimental projects of care in reference to single users or specific groups. Austerity not only imposes cuts, but introduces protocols of control that make impossible the constitution of projects of care based on the contingency and complexity of each person, systems of care that activate devices, actors and resources to support the fragile urban freedom of users.

[4] An example is the protocol created to allow volunteers and recognised actors to use the premises of the MA without the presence of an institutional person, sharing the keys of the premises through a statement of personal responsibility recognised by the SHS.

Today the possibility of this democratic practice of care, as one constituted through empowerment, responsibility, autonomy and equality, can live only if capable of affirming a broad social subjectivation of both the SHS workers and the MA territories. At the same time it needs to rekindle a collective imagination of new institutional devices. Subjectivation and invention are still the main practices for the deinstitutionalisation of care: a practice of deinstitutionalisation that lives in the ambivalence of managing and institution that “we deny”. This can be achieved through a democratic practice of care that makes users autonomous without withdrawing from the public responsibility of care: a practice that empowers the social production of care, that disarticulates the paternalistic practice of welfare, and also avoids the neoliberal drift toward abandonment and misery.

An ecology of care

Let me use the case of the park of San Giovanni, where the asylum was instituted once, as example and allegory. The park opens where the asylum closes and it populates the institutional space through the complex intertwining of different life-forms and initiatives: not only the University, the SHS offices and other public institutions, but also cooperatives, plants, festivals, benches, campaigns, associations. The ecology of the park grows and invades a wider urban political ecology, immersed in the ambivalence of urban life, in the difficult freedom of the city.

In the words of Franco Rotelli, the social life of the park is done of earth and contracts, gardeners and water, saws and lovers and five thousand roses: “but five thousands roses are still missing, and they are for me the sign of the city that is uncertain, they are the cypher of what is possible, of what has not become true in that true life that we wanted to live, for us, for the loonies, suffering brothers and sisters with whom we have done a long walk. A walk that took us far, but not as far as we hoped we would get (but much more far way than their lordship could even imagine). The rose that still does not exist calls for another time, another generation, another energy, another love. Of which no one for sure can today, especially today, make any prophecy: a prophecy done of men and women that can look, and listen, and watch, and touch, and smell, and use their all senses, and cultivate the concrete signs coming out of them: because capable of listening the rumour of life, and touching the earth, and watering the roses, and changing the things.” (Franco Rotelli, 2015)

I propose here “ecology of care” as an operative concept to translate the practices of Trieste beyond their own experience, opening a series of questions and challenges that can be proposed in other *margins* of Europe, throughout the crisis, to imagine recovery as a possibility of transformation for the better: a practice that supports and guarantees the constitutively difficult freedom of urban life.

Thinking in ecological terms implies to “perceive and compose” - rather than programme and dispose - public policies of care around the complex ecology of urban life, in social, environmental and subjective terms. Health and care become a dialectic practice of ‘recovery’ as a healing for the better; transition becomes a practice of change and regulation around the social organisation of commonal living: not the problem of the commons as something to be produced anew, but the question of how to imagine, beyond the crisis and towards an elsewhere, a continuous displacement from the real. A political imagination immersed. This ecology of care can be defined along five different lines.

- **Open system**: Institutional change in other terms can happen when the institution is not analysed anymore as a closed system of equivalences and equilibriums, but rather as a series of dynamics that constitute themselves in the open urban space, the institutional practice "enters outside" in the city, to use a powerful expression written on the walls of the former asylum of Trieste.

- **Transversality**: The institution is not only in the city, but is a multiple body in the ecology of the city, where the logic of transversality challenges a molar conception of separated institutional bodies in the city.
- **Catalogue of practices**: The space of transition is therefore the one in which the institution is configured not through the prescriptive limits of norms, but through a catalogue of practices that intervene and develop in a living world.
- **Common enterprise**: This catalogue of practices is immersed in the urban ecology, in a permanent encountering and engaging of a different set of subjectivities and materialities, in a network of possibilities that is at the same time a realisation of an elsewhere: a common enterprise.
- **N-way interessement**: The practice of care is not in the invention of something new - an expanding revolution -, but a practice capable of destroying and inventing through the interdependence of cycles, therefore always relating to durability and, at the same time, transformation.

Care emerges not as a rational definition of a prescriptive behaviour that evolves through history and is accumulated in the institutional setting, but as an ecology of matters, feelings and engagements that involve a contingent and situated tinkering of care as socio-technical teamwork, in which agents, objects, memories and sensibilities configure healing as a common enterprise of care. A process that aims to nourish and enjoy a finite life, rather than recovering the body, making it healthy and productive again.

Looking at the Trieste contemporary devices, and particularly the MA, through these lenses, a different logic of care emerges: one in which the city is the environment for healing. A city that heals, a city that cares. Using the five lenses I have proposed above, analysing the MA device in ecological terms underlines some crucial innovations developed through these practices.

1. The device indeed is not constructed through the appropriation of the body through the disease, in the closed system of the institution, but through the intervention of the medical practice in the complex ecology of life, with the limits and contradictions of life.
2. The practice of MAs breaks apart the molar logic of the institution and construct the space of care-provision as a transversal connection among different agents and services, through and outside of state-machine.
3. The state-machine is inhabited to do things, to activate resources, mechanisms, possibilities, according to an effectual logic rather than to a prescriptive conception; the citizen/user engages with a catalogue of practices assembled to produce an environment of care.
4. The practice of care is not a static composition of norms, protocols or resources, it rather constitute spaces where the quality of the environment, the mechanism of trust, the mutual interessement from different positionalities constitute the ground of a common enterprise of care.
5. The practice of care is not organised according to a truthful way for achieving health, but as a material possibility of care, constituted in the complexity of life. The space is

one of common responsibility instead of individual competences. An ecology of care rather than a collection of individual repaired bodies.

The possibility of defining this ecology of care as a pragmatic for the provision of public services would need an in-depth research in the Trieste experience, but also the construction of platforms of discussion as well as the definition of mechanisms of "institutional translation" of these devices in different administrative and legal context. It is important to stress, beyond the preliminary dimension of this report the possibility of developing at least three significant lines of research:

- A specific focus of **research on the Micro-Area device,** further developing the existing co-research project, in the attempt of constituting a catalogue of practices and expliciting a genealogy of the singular governmentality of care that has defined the contemporary governance in Trieste. This could be achieved through a mid-term ethnographic research in collaboration with the users and workers of MA; it should also involve the provision of an Independent Programme of Study to empower the participants with critical tools for policy analyses and policy design.

- An **inter-institutional think tank** among similar experiences at the southern European level, capable not only of permitting the exchange of best practices and improve the catalogue of practices in each site, but also of constituting a political voice of users and workers at the European level. Such a programme would involve actors from the Greek solidarity social clinics, the radical municipal governance of health in Spain and the Trieste experience, in collaboration with the Research Group *Entrar Afuera* ("Entering outside"), with Marta Malo de Molina, Marta Perez and myself.

- The constitution of a **social, legal and healthcare investigation** to enquire the extent to which the logic of care implemented in Trieste can be translated to specific urban and regional contexts in Germany and in the rest of Europe. Such a practice of collaboration can be imagined with World Permanent Conference for Mental Health Franco Basaglia, the institute related to the Healthcare System of Trieste that provides consultancy for the development of Basaglian institutional practices at the international level, for example collaborating in the healthcare reform of countries such as China, Argentina, Ecuador among others.

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