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The 'Italian Experience' Reconsidered

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Our analysis of the problems of the Italian psychiatric services has drawn a lively correspondence challenging our findings. In September 1985, we undertook a second study tour in Italy. This is now reported, with notes on specific criticisms of the earlier paper.

The story of the 'Italian Experience' in attempting to abolish mental hospitals and replace them with 'alternative structures' in the community has drawn international attention, because no other country has adopted such an extreme policy by statute. In Britain the policy has been highly praised by a number of observers (Hanvey, 1978; Ramon, 1982; Daniels, 1983; Lacey, 1984; Heptinstall, 1984) who have seen it as a paradigm for British policy.

The query raised in our minds after studying the Italian literature on the subject related not to the experimental services in Trieste, where the reforms began, but to whether the movement was sufficiently widespread and sufficiently successful to be described as a national policy. It seemed clear that the law of 1978 (No. 180, now part of Law No. 833) was being hotly debated, and that there were many places in which it was not working well. Statistics were of little guidance, since they were dated and lacked explanatory power. Empirical testing seemed the only feasible approach, and we travelled 800 miles through Italy, visiting Como, Milan, Pavia, Pisa, Lucca, Florence, Salerno and Reggio di Calabria in a line from the north to the south of the country. We knew that there were supporters of the new law in Milan, and opponents in Pisa. For the rest, our choice of centres was dictated wholly by geography.

In each city, we worked through the *primario*, or consultant in charge of a service. We investigated Diagnosis and Cure (D & C) units in general hospitals, community services, university clinics and mental hospitals. We did not visit Trieste, which had been well-publicised, or Rome, which was too large to comprehend in the limited time available.

Our conclusions were that Trieste was not Italy. The new law had created many difficulties in a country where most of the psychiatric services were chronically starved of resources, and only the Communist Party continued to support it. The other major parties had drawn up proposals for legal revision, which involved the use of the old mental hospitals for medium or long-stay care.

Publications (Jones & Poletti, 1984; Jones & Poletti, 1985a, b) drew considerable professional interest. In the last of these papers in the *Journal* we did not repeat the descriptive material of earlier ones, but attempted to consider the question why, when the real facts about the Italian situation were readily accessible, British observers continued to repeat the myth of unqualified success.

Criticisms

Our *Journal* paper has drawn a somewhat vehement correspondence from the supporters of Psichiatria Democratica. It has been stated, *inter alia*, that we are "in favour of mental hospitals" (Tansella, 1985); that we gave "an inaccurate picture of Trieste" (Ramon, 1985), and that we predicted "the certainty of catastrophe for any country if mental hospitals are abolished" (De Girolamo, 1985). Perhaps these comments will give readers some idea of the general flavour of debate. Neither of us is in favour of mental hospitals, provided that better forms of care can be devised for patients; what matters is the quality of care, not where they are housed. We gave no description of Trieste at all, because we had not visited Trieste; and the comment about "predicting catastrophe" can only be a linguistic misunderstanding. What we did was to set down a series of hypotheses which required testing, and to say that the evidence was insufficient to test them. The main complaint was that we had not been to Trieste, and that instead of taking a longitudinal section through Italy (which gave us some idea of how the law was working), we should have followed the practice of other observers and seen the new system at its best.

We thought that this misinterpreted our intentions. We had been concerned about the descriptions of the reforms as 'the Italian Experience', when it was comparatively easy to show that they did not apply in much of Italy. It was therefore a question of social policy, of studying the implementation of a law; we had not commented at all on 'The Trieste Experience', merely pointing out that Trieste was not Italy. However, we were prepared to learn; and in September 1985, we spent a further three weeks in Italy, visiting services in Trieste, Rome, Ferrara,

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and Bologna—all known to be operating on the principles of Psichiatria Democratica. It says much for the generosity of our Italian hosts that, despite what they perceived as criticisms of the reform movement, they were hospitable and friendly, allowing us free access to their services and discussing both practice and ideology at great length.

Trieste: the achievements

The Trieste services have been described in considerable detail by Bennett (1985). They operate basically through seven community psychiatric centres in different parts of the city and district, and we were able to visit five of these. The relationships between staff and patients (called 'users') are warm and caring; there are no white coats, no appointments, and no queues of patients waiting to be seen. The atmosphere is more like that of a club than a medical centre. In the centres in the city, patients come when they like, talk to whom they like, stay as long as they like, and leave when they like. Some treat the centres as lunch clubs, some come seeking the help of the staff (psychiatrists and nurses, with a psychologist and a social worker), and some work there, part-time or full-time, helping with the cooking and cleaning. This is not the traditional kind of patient labour, which is considered exploitative: there are cooking, cleaning, and agricultural co-operatives, which patients join; by an arrangement with the trades unions in the city, these pay full union rates. The health district budget provides the money on contract if the co-operatives tender is accepted.

There is no great distinction between staff and 'users'. Everybody is on first-name terms, and dress is informal. The presence of volunteers, some from other countries, helps to foster a sense of community. The main event of the day is the group meeting, when a variety of problems relating to individual patients or to relationships within the centre are talked out; but many other discussions go on between staff and patients, staff and volunteers, volunteers and patients, patients and patients.

Some patients live in their own homes, while others live in group flats near particular centres. These vary from small homely apartments, usually rented from the municipality, where patients have their own possessions and live a comfortable domestic existence, to large apartments which are very similar to hospital wards. In the former type, nurses come in regularly to supervise shopping, cooking, and cleaning, and to check on medication. The large apartments, for patients with limited degrees of independent functioning, tend to have full-time nursing staff. The nurses we met were young, cheerful, and had no formal training, though they had mental hospital experience; the patients greeted them as friends. They were more than home helps or care assistants, because they were capable of monitoring the patients' progress and reporting back to the psychiatrist. Psychiatrists visited the group apartments, and the degree of lateral support which they and the nurses had created between patients was impressive. We were told of cases in which quite acute psychotic episodes had been contained by doctors, nurses, and flatmates working together, without recourse to hospitalisation.

The City's Diagnosis and Cure unit in the general hospital has only eight beds. When we visited, all were empty—a great contrast to the crowded D and C units we had seen in other cities, where staff worked desperately with urban crises on locked wards, and patients could stay for months because there was nowhere else to send them. The consultant in charge thought that it was possible to run a service—even for the kind of 'heavy psychiatry' which came his way—without the use of mental hospital beds. Patients are usually kept in the unit only for a few hours, before being referred to a centre. Each of the centres has between six and eight back-up beds, and their psychiatrists work three or four shifts a month in the D and C unit, to keep in touch with the general hospital services. Most new referrals come in from the Casualty Department and the D and C unit; we were told that GP referrals to the psychiatric services are comparatively rare.

There is thus a network which begins with the D and C unit, acting as a crisis centre, extends to the mental health centres, and then spreads out into the apartments and patients' own homes, offering varying degrees of care and treatment. ECT is not used, and the use of medication appears to be less than in some other parts of Italy. The system is by no means as casual and informal as it looks on first examination, and as the psychiatrist at the D and C unit commented, the personal cost of involvement for the staff is high—perhaps higher than in more orthodox systems run on the medical model.

San Giovanni, the old mental hospital, was officially closed in 1980, to the accompaniment of public celebrations, but in fact, it is still very much open, though its use has been diversified. The hospital is built on a pleasant wooded site, on the villa system, and now houses the administration of psychiatric services, one of the seven centres, the co-operatives, the Arts Centre and a number of apartments for ex-patients. One of our critics (Ramon, 1985) complained that we did not understand the importance of 1968 in the work of

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Psichiatria Democratica—the year in which left-wing students and workers combined in marches and demonstrations to try to bring about a more democratic society. We can only say that the spirit of 1968 is still very much alive in Trieste, and San Giovanni is its home. A block of patients' apartments (formerly doctors' flats) is labelled 'Casa Rosa Luxembourg'. A roughly-painted inscription along one wall reads 'Prison = asile = usine = école', a slogan left by a visiting group of French Communist students, expressing the Foucauldian principle that prisons, mental hospitals, factories, and schools are all agencies of capitalist control (Foucault, 1975; Jones & Fowles, 1984). Bearded young men play guitars, and sing "Blowing in the Wind", which must still be Trieste's most popular song, and talk of 'power to the people'. There are no punks, and we were asked on several occasions what Britain intended to do about 'the punk problem'. There is a sense in which it is still 1968 in San Giovanni.

It seems no accident that 'graffiti' is an Italian word: the walls of the San Giovanni villas express a natural delight in slogans, cartoons, and symbols. On Q ward, now empty, someone noticed that the letter Q looks like a child's drawing of a cat, and added ears. In successive pictures, the Q-cat stirs, stretches, and pads away to freedom. There are pictures of Marco, the horse made of wooden struts and plaster, who was pushed through the gates and surrounded by a ring of dancing children: when the hospital was symbolically closed in 1980; not a Trojan horse, as one commentator thought (Heptinstall, 1984), but a model of a real and much-loved horse which pulled the laundry cart collecting dirty sheets from the wards.

There is a special sense of carnival—Trieste is not far from Venice—expressed in the making of fantastic masks and posters, in dramatic entertainments and jazz concerts and happenings. San Giovanni is livelier than many a university campus, and a long way from the realities of mental hospital life in most of Italy. At the cost of possibly being dubbed 'anecdotal' or 'unscientific', we have tried to set it down as we experienced it. It is, above all, an *experience*—not to be described in terms of bed-days and clinic attendances and staff man-hours.

Trieste: the reservations

Like other visitors, we were attracted by this system (while continuing to point out that it was quite unlike the services we had encountered elsewhere in Italy: some of these had the enthusiasm, but did not have the resources). However, we had four major reservations, and it is necessary to set these down.

First, San Giovanni is not closed in anything but a symbolic sense. In addition to the 'Arts people', the co-operatives, the centre and the administration, it houses:

(i) over 200 patients who 'just happened' to be there when the reforms took effect and could not find outside accommodation. As in the community services, some of these are in small, personalised flats; but the degree of nursing support is greater, and some 'apartments' for very deteriorated patients, are simply hospital wards under another name. A locked ward for 48 patients suffering from senile dementia was particularly restrictive and unsuitable.
(ii) 15 beds in an alcoholic unit.
(iii) 20 beds for severely mentally handicapped young people, some of whom were lying on the stone floor of a balcony behind a locked door.
(iv) 40 beds in a traditional university clinic.
(v) an unknown number of beds in a hostel where patients attending the drug clinic (some of them volunteers in the Arts Centre), homeless ex-patients, and foreign students stayed.

To these categories can be added:

(vi) approximately 50 beds in the centres.
(vii) eight beds in the D and C unit.
(viii) perhaps one-third to one-half of the beds in the 100-bed *Allogia Popolare,* the city's public lodging-house, where a regular psychiatric clinic was maintained until recently.
(ix) an unknown number of beds in *convenzionati*—private nursing homes taking patients on contract from the public services, to which many patients over the age of 65 have been transferred. It is frequently said that "there are no *convenzionati* in Trieste". This is only correct if the cut-off point is taken as 65.

The total of all these beds cannot be far off that of a medium-sized mental hospital. Not all are considered the responsibility of the psychiatric services (for example, the drug clinic and the alcohol clinic are separately administered), but this is a matter of drawing administrative boundaries rather than of psychiatric need or social reality.

Second, we were concerned about the scope of the service. The emphasis is very much on the younger, psychotic patients, and on the containment of bizarre episodes. We appreciated Bennett's apprehension (1985) that the centres, while geared to the needs of such patients, might "overlook the needs of quietly deteriorating patients". A system which relies on emergency admission, self-referral, and word of mouth rather than on systematic case-recording may not fully meet the needs of patients suffering from depression, anxiety states, or long-term psychoses.

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Third, the service appears not to provide for the elderly senile mentally ill, unless they had been in hospital before 1980, in which case they are regarded as victims of institutional oppression. It is assumed that, with the demise of the mental hospital, these patients will die off in time and not be replaced; but Trieste has an ageing population. Over 30% of its inhabitants are over the age of 65 (Gianichedda, 1985), and a system which virtually excludes them from psychiatric care seems, to put it mildly, unduly optimistic.

Fourth, it is important to note what the Trieste services do *not* do, in terms of professional practice. As elsewhere in the Italian psychiatric services, there are no regular programmed therapeutic activities. A volunteer who attempted to keep a diary of activities in one of the centres gave up, because there were no activities apart from discussions and the work of the co-operatives. In the past, patients have been exploited and used as an unpaid labour force, so that this reaction is understandable; but some patients could benefit from the kinds of occupational therapy, educational classes, health and beauty classes, and other activities which are standard in many British day hospitals and centres. Patients should not be compelled to join in such activities, but perhaps they should have the choice, since many of them lack the initiative to structure their own day. (On the other hand, we are aware that the differences between Italian and British practice could relate to cultural norms rather than to psychiatric norms. Perhaps our emphasis on activity is the result of living in a colder climate.)

The discussions in the centres on patients' needs were practical and relevant in everyday terms, but there seems to be no use of psychoanalytic insights (which are considered bourgeois), group therapy techniques (which are thought to be manipulative), or any of the modern developments in social work, such as family therapy, the systems approach, or network theory. Specialists in any of these areas would find the Trieste system low-powered—its real power lies elsewhere. There is no systematic case-recording, no performance review, no outside monitoring, no staff development system, and no systematic training. Whilst recognising that these devices may become mechanical and take the place of human concern, there is an argument for having some elements of both.

Finally, behind the innocent and frolic radicalism, there are more serious political implications. We did not wish to enter into ideological debate, but most issues in Italian life are highly politicised, and we were repeatedly told that it was impossible to divorce the practice from the ideology. The principles, as far as we could elucidate them, are as follows: the mental hospital system is an expression of capitalist oppression of the workers. Therefore 'the closure of the mental hospital is the point of departure'; the people must rise up and demand that mental hospitals be closed. Doubtless some patients will suffer in the transition period, but 'it is necessary to take risks'. Eventually, the people will rise up and demand good community services, but the real aim is 'the transformation of Italy'. What has been done in Trieste can be done elsewhere—all that is necessary is that "psychiatry should deinstitutionalise itself".

The same phrases were used so frequently in discussion that we came to the conclusion that this was a closed system of thought, insusceptible to rational argument. We pointed out that the mental hospital was not closed, and that the Trieste system might carry very much more weight in international circles if the psychiatrists concentrated on publishing research results on the positive aspects of the service, rather than creating a credibility gap with slogans and doctrinaire statements. The reply was "You do not have the correct frame of reference": all that is necessary is to be ideologically sound—and to close the mental hospital.

The Trieste experience appeals to the non-rational side of the human mind. Demands for liberty, equality, and fraternity still create resonances and enthusiasms, powerfully reinforced by symbols and slogans of a highly imaginative kind. But three points stand out: first, the demand is for total acceptance; analysis and questioning are swept aside or treated as evidence of adherence to 'the medical model' or extreme Right-wing politics. There are also rigidities of thought on the Left. Second, in a country with a Catholic heritage, symbols and dogma still have a considerable power. Third, both have a new impact through the mass media; Psichiatria Democratica's use of the media has been highly professional.

Can the Trieste experience be replicated?

The insistence that what has happened in Trieste can be replicated anywhere else is worth further examination. The Trieste psychiatric services have certain built-in advantages. The district is discrete in geographical and administrative terms—a promontory largely bounded by the Adriatic and the mountains. It comprises a single health district, which means that it is possible to plan services for the district as a whole. By contrast, Milan has 19 health districts, and Rome has 20, each with its own health budget. In Trieste, one-to-one relationships

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between the psychiatric services on the one hand and the commune, local trades unions, and related agencies on the other are possible, as they are not in most cities; administrative complexity makes community care difficult. The movement started at a propitious point in time, and with a charismatic leader, Professor Franco Basaglia, who generated enthusiasms and gained much popular support. The Region supports the service well—in terms of population served, the annual budget is at least four times as high as that of some psychiatric services in Rome. One point which is generally overlooked is that a 'core and cluster' system involving group flats needs an adequate supply of housing: Trieste has a declining population, which means that there are apartments to spare at relatively low rents. Gianichedda (1985) records a steady decline, involving both natural and migratory shift, of over 20 000 (about 7%) over the 20 years from 1961 to 1982; as a result, "the decrease in population has left many houses empty and these are now unlet. The official figure shows 27,860 empty rooms".

Elsewhere in Italy, it is more difficult to implement the principles of Psichiatria Democratica. In Ferrara, though there is an insistence on the importance of symbolically closing the mental hospital (the *primario* has personally painted a large crack in one wall, and expects to have the main gate ceremonially demolished next spring), there are still 200 or more patients in the old hospital, for whom rehabilitation seems remote, and a further 120 in a converted convent about two miles out of the city. A disused part of the hospital is being converted into flats by the health district, but the psychiatric service will only be able to control the use of four. Long-stay patients who have left the hospital have either returned to their own homes or have gone to live in the former Jewish ghetto—a poor part of the city: "They are tolerated there", we were told.

The Ferrara team has a strong psychoanalytical orientation, and works through out-patient clinics (with appointments and individual interviews); their work focuses on patients with a diagnosis of depression or anxiety state. There are no clubs or day centres. The elderly confused and the quiet schizophrenic are regarded as the responsibility of the Social Services, and violent or dangerous patients as the responsibility of the forensic hospitals. The team does not deal with drug or alcohol abuse, and takes the view that the problems of young people are best dealt with by family therapy. When asked how they would spend additional finance, if it were available, the psychiatrists opted for professional training—for psychiatrists, for social workers, and above all for nurses. Though the ideology was similar to that in Trieste, the practice was fundamentally different. The psychiatrists were primarily interested in the *casa interna*, the house of the mind, rather than the *casa externa*, a house for the patient to live in.

In Bologna, which has three health districts, we visited one where the *primario* subscribed to the principles of Psichiatria Democratica, but took the view that only national mental health planning would enable Law 180 to work as it should. He was responsible for a total of 290 beds, many of them occupied by chronic patients and all run on orthodox medical lines, with one locked ward. The community services consisted of an outpatient clinic and some domiciliary work by community psychiatric nurses.

In Rome, we were able to talk to three University Professors of Psychiatry, all with a responsibility for running services; all three are members of the Italian Communist Party. Two are members of Psichiatria Democratica, but one has left the organisation because he thinks it is becoming dated; he took the view that it was insufficiently in touch with recent developments in psychopharmacology and community medicine.

Of the 20 health districts in Rome, one informant rated three or four as good, five or six as 'medium—improving', and the rest as poor. There are two large mental hospitals, and only 45 Diagnosis and Cure beds; the pressure on services is extremely acute. There are few psychologists or social workers available, and few if any group flats—Rome has a housing shortage.

One professor thought that if he had sufficient resources, he could set up a service on Trieste lines; he attributed the main problems in applying Law 180 to the misapplication of funds. Of the money available for psychiatric services in the Region, roughly half goes to private Homes (*convenzionati*) and private psychiatric hospitals. Public mental hospitals take up nearly another quarter, and the whole of the community services in 20 districts run on the equivalent of £14 million a year.

Another professor, in a very poor district of Rome with acute social problems, said of Trieste "that model cannot be reproduced", and that if he had sufficient funds to develop the psychiatric services, he would prefer to spend it on more fundamental needs in the community: homes, schools, getting rid of squatters' houses. "The people here don't live—they survive".

All three were in favour of an eclectic approach to patients' problems: psychopharmacology, group and individual therapy, social therapy, and community support. We were able to visit centres

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in Rome—notably the Albedo Centre and the Random Centre—where advanced training takes place for doctors and other professionals. The emphasis is on multi-disciplinary work of a high professional standard including both medical and psychoanalytical techniques.

Conclusions

"Trieste is a flag" said one professor. It seems that the Trieste services, which rely so heavily on symbols for their impact, have in turn become a symbol—of humanitarian concern for patients' welfare, perhaps of nostalgia for a period in time when the 'transformation' of Italy' seemed politically possible. Today, elsewhere in Italy, Psichiatria Democratica seems to be diversifying, coming to terms with adverse administrative situations, and accepting new developments in medicine and the social sciences. It was significant that when we asked a group of psychiatrists in Trieste why, if this 'transformation' was merely a matter of 'deinstitutionalising psychiatry', they did not move and tackle the problems elsewhere in Italy, the response was "But the administration would be against us". Perhaps it is also significant that, in the last two years of his life, Franco Basaglia moved to Rome, where he took on the administration of psychiatric services for the whole of the Lazio Region, i.e. the city and the surrounding area. Basaglia was a man of extraordinary courage.

For much of our time in Italy, we remained mystified by the insistence of Psichiatria Democratica on 'closing the mental hospital' when it was patently obvious that mental hospitals were not being closed. As in other countries, which do not employ the same rhetoric, their populations have been reduced, and some community services have been developed. In Trieste, the community has been brought into the hospital and the hospital services into the community in a unique way which blurs the distinction between the two; but changes of nomenclature and the re-drawing of administrative boundaries do not dispose of the problems of patients, and the danger that the needs of chronic patients might be overlooked seemed to us a real one.

It was possible that 'closing the mental hospital' was no more than a slogan for public consumption—a latter-day equivalent to razing the Bastille—and that Psichiatria Democratica was well aware that it did not correspond to the reality. However, we did not think that this was the case; despite our ideological differences, we never doubted their good faith or their complete sincerity.

A second possibility was that this was the equivalent of 'gate fever'—a condition well-known in prisons and concentration camps, in which the actual breaking down of the gate becomes more important than a consideration of what life is like on the other side. Before the 1970s, many Italian mental hospitals were, by all accounts, uncommonly repressive. There was nothing equivalent to the British movement for voluntary treatment under the 1930 Mental Treatment Act or informal treatment under the 1959 Mental Health Act, or the open door movement of the 1950s. In the circumstances, 'gate fever' would be understandable, but typically, the symbol comes adrift from reality.

There is a third, more sociological explanation. In common parlance, a prison or a mental hospital is merely a building, a physical landmark; but in Marxist sociology, which has been very influential in Trieste, it is also a power-structure, constraining and controlling the inmates. So San Giovanni is 'closed' in the sense that the hospital administration ceased to exert power over the inmates, but it is not 'closed' in the sense that some of them continue to live there and to receive psychiatric and nursing services. The distinction is not a particularly subtle one, but it has led to massive misunderstandings. When the Trieste team say "We closed the mental hospital", they do not mean "We closed the mental hospital", They mean "We broke the power of the mental hospital over the patients".

We do not claim to have seen the whole of Italy, nor to be able to make detailed and authoritative comparisons of specific issues; but we know enough to be able to state with confidence that the more extreme claims made for 'the Italian Experience' have been highly misleading. There is now a growing literature on the subject in English, including the symposia published recently by the *International Journal of Mental Health* (Mollica, 1985) and *Acta Psychiatrica Scandinavica* (Perris & Kemali, 1985). We hope that readers will be able to study this literature, and make up their own minds.

Notes on correspondence

Shulamit Ramon (1985) mentions 12 political proposals for the reform of Law 180, which come from all the major political parties except the Communist Party. The proposals of the Government, the Christian Democrats, the Liberals, and the Republicans, which we have analysed, all provide for "units for protracted hospitalisation", "protracted stay units", or the "restructuring" of mental hospital accommodation to provide for chronic patients. We did not at any time compare Franco Basaglia to Winston Churchill.

Tansella (1985) evidently missed the reference and

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the footnote in our first paper to the longer and more descriptive account (Jones & Poletti, 1985b), which describes in some detail the rationale of our investigation, the research design, and the places visited. We did not publish the names of our informants, and have not done so in the present paper, because we had many enquiries from readers wishing to visit the Italian services and we thought that our sources should be protected. Many of the doctors and other professionals who were kind enough to spare us time were working under great pressure. Of the sources which Tansella quotes, we were familiar with most published up to and including 1984, but the Scala & Gritti (1985) paper, was published after our own went to press.

In Jones & Poletti (1985b), we distinguished very clearly between those Italians who believe Law 180 is a good law which failed in implementation, and those who believe that it is a bad law. Doubtless this debate will continue.

De Girolamo (1985) states that "compulsory admission is easily implemented in case of need"; that may be the case in Cremona, but is not so in Rome, where there are 45 D&C beds for a population of five million. The Law specifies 15 beds for 150,000 population, but many areas are still below this level of provision.

Discussions about the statistics for *convenzionati* or suicides are not useful because the data are unreliable. Some figures of *convenzionati* certainly exclude the over-65s, or patients placed in general, rather than psychiatric nursing homes, while numbers of suicides are notoriously difficult to assess, particularly in Catholic countries. We have no figures for forensic hospitals, but understand that these are given in terms of bed-days, not of patients resident or admissions/discharges. It is true that the Trieste service does not make a practice of sending patients to forensic hospitals: we were told that the practice is to keep them in the local prison, where they can be visited by a psychiatrist from one of the centres with a view to their ultimate rehabilitation.

Bourne (1985) asks whether we attended the Psichiatria Democratica exhibition in Sheffield last year: we were in Italy at the time. He also asks whether it can really be true that "we can learn nothing from the Italian experience": we learned a great deal about Italy, but do not think that the solutions of Trieste are transferable to a British context.

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