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Equity in Health and Health Promotion in Urban Areas

Multidisciplinary Interventions at International and National Level

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Pathways for Therapy and Urban Health in the Field of Mental Suffering. Illness Narratives from a Residential Complex for Public Housing Assistance in Rome, Italy

Silvia Iorio, Alessandra Battisti, Valentina Gazzaniga, Maurizio Marceca, Giuseppe Ricotta, Lorenzo Paglione, Alberto Calenzo, Livia Calcagni, and Marco Tofani

Abstract The aim of this paper is to analyse and interpret, using a qualitative approach, the relationships between mental health and social vulnerability, by studying a limited population group of in the city of Rome, Italy. Specifically, we analysed two aspects. On the one hand, we looked at the representation, perception and therapeutic management of mental distress based on meanings and symbols that are associated with these issues by the local population. On the other hand, we also extended our analysis of this discomfort to the action of political-economic forces that lead to a sort of *incorporation* of inequality and social injustice. Through the analysis of illness narratives, there is the possibility to demonstrate how socio-economic and spatial segregation are intertwined with health and social inequalities. From these results, the authors highlight the need to adopt a multidisciplinary approach to equity in health with regard to 'urban health'. The goal is that of overcoming inequalities in health and social-health care through the analysis of psycho-social-environmental

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processes and the impact that these processes are able to have on objective and perceived health.

Keywords Marginality · Mental health · Illness narratives · Health care seeking behaviour

1 Introduction

In recent years, there has been an increasing interest in the study of the relationship between the area of residence and health. Internationally, relationships among environment, social vulnerability and health have been observed in several metropolises. However, there is currently a lack of standardised tools that allow for a proper reading of the phenomenon of local inequalities in health and daily life. Since 2016, our team at the Sapienza University of Rome on Urban Health and Equity in Health—in collaboration with ASL Roma1, Municipio XIII, INMP (National Institute of Health, Migration and Poverty); and the DEP (Department of Epidemiology of the Regional Health Service of Lazio)—has worked to put together an infrastructure of prototypical analysis that can facilitate further studies aimed at adequately grasping the complexity of the relationships between inequality in health, socio-environmental and economic discomfort, as well as individual and collective health. Faced with the interest in achieving meaningful, fair and lasting solutions for contrasting and reducing health inequalities, the current lack of analytical reconstructions of the system suggests the need for new multidisciplinary approaches, oriented towards the quality of life within an 'ecological' model of health [1].

The goal of this research work is that of gathering a greater understanding of the phenomenon of mental health of the population living within the "temporary accommodation" (housing assistance) complex called "ex Bastogi" in Rome, Italy. Interest in this type of housing stems from the peculiarities and unique characteristics of the area under investigation–after being delineated over the last twenty years as an impregnable fortress, these apartments appear to be now geographically isolated and culturally distinct from the rest of the city. Referring to other studies that analyse its specific characteristics, the complexity of the discomfort found in Bastogi is outlined as a spiral of marginalisation due to several correlated factors: urban degradation, illegal occupation and squatting, unemployment, relational and economic poverty, social exclusion of fragile subjects (minors and elderly in a state of abandonment, irregular migrants, former prisoners), intra and intra-family violence, prostitution, crime and others. In addition, there is also a noteworthy part of the population suffering from some of the most tragic social diseases, including drug addiction and HIV. Moreover, the inadequacy of housing, the illegal occupation of common spaces, the deteriorating conditions of the buildings, the precariousness of the housing situation, due to the vain expectations for the allocation of permanent houses by the Municipality, have all strongly influenced the daily life of the inhabitants, negatively affecting the efforts of integration with the rest of the citizens and

nullifying the hopes for an effective recovery of their condition of discomfort [2]. From the framework outlined to date, there is a clear relationship between the condition of degradation and marginality experienced by the inhabitants of Bastogi and any obstacles to access and accessibility of social and health services, generated in part by bureaucratic and organisational barriers, but above all structural issues, with significant risks to individual and collective health. Specifically, our analysis focuses on two aspects: on the one hand, the representation, perception and therapeutic management of mental distress based on meanings and symbols that the local population connects to mental unease and healthcare; on the other hand, the analysis of this discomfort to the action of political-economic forces that make it a form of incorporation of inequality and social injustice. In this regard, a structuralist perspective highlights how "risky behaviour" of the local population does not depend solely on individual choices, but also on the social, cultural and material conditions in which this type of behaviour is embedded [3]. Consequently, the processes of treatment cannot be limited within the space of the doctor-patient relationship. Importantly, efforts must be also directed towards the removal of the social structures that cause disease and illness. This theoretical paradigm therefore makes it possible to recognize, within the social-health field, the etiological agents and their effects, combining structural processes with personal perceptions and experiences of pain, trauma, stress, and discrimination. The complexity of certain phenomena, however, necessitates new models of integrated social services and health care based a "proximity", with a close and synergistic collaboration between the different actors of social services and health care in the public sector and even in the private social sector. This needs to be done without forgetting the importance of mental health, through the focus of scientific and operational interest on the relationships between the individual and the environment, where mental suffering itself indicates the lines of fracture and marginalization of the relationship between institutions and the population.

2   Methodology

The methodology used is based on qualitative analysis, typical of corresponding and pertinent anthropological science (1) in an ethnographic study within the housing and residence over a period of about two years, (2) to an experimental culture that combines the perspectives of biomedical, psychological and social disciplines through the formulation of interviews with local and regional social and health institutions (for a total of fifteen interviews), (3) the legitimacy of the data produced by the practice ensured participant observation, (4) carrying out thirty in-depth interviews and semi-structured interviews.

Primo Levi developed the concept of "grey area" (or "grey zone") to describe the ethical desolation imposed by the Nazis interned in concentration camps—in this zone, survival imperatives prevail over personal dignity, forcing prisoners to inflict upon one another unbearable cruelty. Far from wanting to draw a parallel between the Nazi extermination and social exclusion strategies implemented in a modern

metropolis, it seems nevertheless extremely useful to think about the agglomeration in question as a "grey zone" of contemporary society, where unbearable conditions are structurally imposed and naturalized. It is certainly not a closed placed, or rather of a total institution in Goffmanian sense, yet it is essential to read the collected data and important factors such as drug addiction, unemployment, lawlessness and more, with a mindset that shows the borders of a scenario where vulnerable social groups find themselves.

This forcibly materialistic attempt [4, 5] to approach the area, as opposed to the approach of personality culture [6], allows for the framing of gentrification phenomena in the real estate market, the industrial crisis, labour restructuring, flexibility of the outsourcing, and the precariousness of educational institution and social and health institutions as forms of structural, political and symbolic violence, in turn outwardly expresses in daily violence that reinforces inequalities. The concept of "everyday violence" used by the anthropologist Scheper-Hughes (1996) places attention on the social production of indifference to the brutality expressed in interpersonal interactions and in daily routines. The residents of Bastogi, much like those who live in other contexts of exclusion:

Far more numerous are the victims of economic change or institutionalized discrimination by a perverse political and economic system. They do not passively accept their fate as fourth-class citizens. They struggle, with determination, to earn money, gain respect, and lead lives that make sense. Tragically, however, it is precisely this struggle against—but within—the social system that aggravates the suffering of their community and destroys hundreds of thousands of individual lives ([4]: 9).

Among all the problems that individuals face, those that involve the sphere of mental health put in place the manifestations of uncertainty or more precisely of lability, question in a critical sense the values on which social and personal life recalls. Ernesto [7] had highlighted the cruciality of the condition of lability, as an agent of construction of meaning at the origin of the social drama.

This anguish is not really about anything, but [rather] about the relative non-being that is the non-existence of the presence in the historical becoming, the non-existence as a centre of decision and choice according to distinct operational powers: it is the experience of a definitive catastrophe. The forms of the vital or existential risk of presence are manifold: the collapse of the distinction between self and world; the outflow of presence in the world or feeling "acted", "possessed", "invaded" by the world; the experiences of incompleteness and strangeness and the loss of the sense of reality; the specular imitation of [what is] happening and [the person's] will blocked by catatonic amazement; the shattering of essential unity in the plurality of simultaneous or subsequent psychological existences; the cyclical alternation of depression and mania; the uncontrolled discharge of destructive impulses; and further, becoming more specific, according to the indications that psychopathology provides in a heuristic manner. These psychic conditions of crisis, where they remain without redemption or with inadequate redemption, are incompatible with any form of cultural life, and precisely in this lies their extreme riskiness, their catastrophic character that anguish denounces and emphasises [7]: 58).

In this sense, for the inhabitants of Bastogi, talking about mental health means allowing for the expression of social tensions that run through this environment. Through the language of psychological malaise, worries about poverty, housing insecurity, domestic violence, loneliness, and job discrimination all emerge. Those interviewed bring their own conception of their illness to the plot, as a dynamic product of the relationship between a subject and the socio-cultural environment. Depression, schizophrenia and other disorders narrated by displaced and marginalized inhabitants of the residence become metaphors codified through which they express the precarious and unacceptable existential condition—metaphors through which they make clear the link between the socio-political order and that of the personal discomfort.

The information gathered in the transcripts of the numerous interviews constitutes a *corpus* of stories of psychic suffering, crisis and other experiences, highlighting the cause or effect of personal or family hardships over time. During this research work, thirty-two interviews were gathered from people who were diagnosed by the local Mental Health Center and Health Service Clinic. Of these, twenty-two were women and ten were men, all regular or irregular residents inside the residence. The stories told in their interviews underlined different textures through which mental suffering was evident. Two models under which the experiences of the disease can be defined as: (1) The most common form of story tells of how the physical and mental suffering started from a great emotional trauma due to precarious housing or job loss. In these narratives the trauma associated with the initiation of the disease acquires a powerful effect in forming the central meaning and nature of the story; (2) the second form of story regards relationships in general, defined by conflicting factors and inequality.

3 Discussion: Therapeutic Pathways and Incorporation of Inequalities

The data that emerged from this study showed a great discrepancy between local representations of mental distress and the institutions and those who classify disease and illness. These considerations lead us to look at the problem of normality and abnormality in the conceptual framework of a local cultural model. In a community context in which violence, deprivation and dependency are delineated as "normalized" factors, it is clear that the perception of discomfort reaches degrees that are quite distant from that which is representative of the general classification parameters for tolerability. In this regard, Didier [8] proposes an analysis that allows for the consideration of the individual dimension of the disease as well as the political and social setting. Therefore, health is to be defined as a field full of struggles, with the aim of obtaining legitimacy, which, in turn, constantly redefine this field. Health is thus analyzed at the same time in terms of concept and space, as culturally and politically determined. An even more interesting concept in this regard is offered again by Fassin—the idea to approach the issue of public health through the

analysis of these dynamics, continuous adjustments, route changes, contradictions, negotiations in which actors are involved or to which they give rise, in turn putting different resources and capital into play, in relation to historical and social changes. An important role in this field is that of the studies and work of Paul Farmer [9]. As we have already highlighted, he has developed an analytical perspective that allow us to grasp the subtle links between the individual experience of suffering and networks of economic and political relations, emphasizing the individual incorporation mechanism of collective dynamics. Starting from an analysis that is geographically large and historically deep, Farmer tries to develop a perspective that can explain suffering by including the individual biography in the wider matrix of culture, history and political economy, going beyond what is ethnographically visible. The analysis of the individual aspect of suffering makes it possible to grasp the influence that visible social and political forces only have on the individual at a macro-level, which act silently in the daily lives of the most vulnerable social groups.

The analysis of etiological reconstructions is certainly useful for a first level of investigation, in order to highlight the specificities of the different cognitive and value-based approaches. Starting from the study of single etiological interpretations, the analysis carried out in the residence was extended to the study of important social issues that were sometimes overlooked, such as economic insecurity and existential consequences, domestic violence and the perception of the crisis of a local culture. This crisis is also evident in the increasingly apparent disconnection, created between the level of interpretation of illness and the structuring and planning of a course of treatment. Therefore, taking into account the use of therapeutic resources available in a given territory, without being limited only to health services, the behaviour of the population of the area was analysed in order to determine how its inhabitants make use of multiple therapeutic strategies put into place when distress is recognized by the individual as well as their family group.

The therapeutic pathway, defined by Anglo-Saxons as "health care seeking behaviour", is understood here as a process that consists in the diagnosis-treatment course of action in response to a pathological case, as well as the set-up of networks, roles and behavioural procedures that are defined in specific circumstances [10]. We must also consider that the course of treatment, at a structural level, is a constantly ongoing process in which individuals can make different choices, alternating explanatory models and different therapeutic approaches. The people studied and interviewed move in the field of therapy in a pragmatic fashion, often not taking into account criteria such as consistency and incompatibility, yet rather returning to their own choices, experimenting with strategies and alternative solutions on their own bodies. In fact, there are a number of people whose therapeutic behaviour is characterized by the strategy of "intermittence of care", based on moments in which the person continues the dialogue with Health Services, alternating with times in which they suddenly detach and distance themselves from public health care.

Marcia

She is 60 years old. She works, obviously paid under the table, at the home of an elderly lady who also lives in the residence. "I've lived here for many years, it's gotta be more than twenty years! I've always got by with these chores at home of

those who are better off than me. Of course, since I got sick, it has been a bit more difficult." A friend advised her to contact the Mental Health Center of the local clinic *[ASL in Italy]* about 5 years ago. "*No one had ever helped me out, then came this man, and as we talked about my situation he recommended the CSM [Mental Health Centre]. So I went a few times to talk to the psychiatrist and social worker. Sure, at first I wondered if I was really that crazy by having to go to visit that place, but then I asked around and I realized it was quite normal to go over there.*" Marzia had her first episode of great suffering at eighteen. She describes it as a "*breakdown*" and attributed the causes to her concerns at that time. "*You know, I lived with my family in public housing nearby and I had a little girl with me … I was living alone, because the child's Father had the bright idea of getting engaged to another girl after I got pregnant. So I was not exactly happy. In my house we lived between the screams and despair, not knowing what to eat and where to get money to get by … and so, at that time, I was sick for the first time, I spent months on end just crying! *". She arrived here at the housing facilities after being raised in public housing, so passing from an already critical housing situation to an even more precarious one. The second incident took place six years ago, at the time when her current partner was indicted for drug dealing. "*I'm always sick, I have headaches. You know how long I've tried to figure out why the hell I had this pain? I thought I had a brain tumour, I thought of so many horrible things and I got a number of tests prescribed. I am exempted [she doesn't pay copayment or fees for health care] so I've always done check-ups but nothing ever came out.*" Marzia reports that the doctor never gave much notice to the descriptions of her illness. The prescription of clinical tests was generally the result of her persistent requests. "*No one has ever helped me. Here we are all in bad shape, and what can I say to a doctor? At best, they tell you to go see a social worker, but if you think you have a disease that's not where you are looking for help. You ask all around to find people who have the same problem and go down so many roads.*" Once she arrived at the CSM [Mental Health Centre] and after receiving a diagnosis of depression, Marzia followed, for a few months, the plan and drug treatments that were chosen, however she later moved gradually away from the health care setting. "*What can I say … the CSM prescribed me drugs, advised me to find more stable and rewarding work, but after a while I moved away. I have always had odd jobs, that's fine work as well. Then, with the drugs, I was also better, but the idea of depression, for me, was not enough to explain my illness.*" During these five years, starting from the first interview, she has periodically called the CSM in order to try to resume the interrupted path, but after a few meetings Marzia always go back to her request for prescriptions of further clinical tests.

Investigation and studies of the therapeutic approaches and pathways focus on what people do when they feel sick—while behaviour, rituals, words and therapeutic options of the sick are closely related to their interpretation of disease, elaborated within a social context and setting. These ideas include the interpretation of symptoms and recognition of the disease as such, its name, the etiology and prospects regarding possible remedies. It is a body of representations and orientations of which the individual and their group have as part of their culture, which, as we have seen, the body order and social order are correlated [11]. As Sylvie Fainzang wrote:

I start from the hypothesis that the search for a medical cure cannot be regarded as the only determining factor in the choice of therapy. This choice is also connected with the interpretation of the illness end with the social tensions which that interpretation expresses. On this basis, I study the behaviour of sick people in the context of their personal histories end cultural identity, and in the light of the wider life of the commune. This will lead to a reconstruction of the situation of elements belonging to different levels of social life and thought systems, and will provide an explanation for paradoxes like the apparent recourse on the part of a patient to what he regards as less effective medical treatment [12]: 42).

The study of the therapeutic approaches and planning should therefore allow for an understanding of the behaviour of those suffering, within the context of his or her individual experience, characterized historically and then inserted in a wider social dimension and setting.

The case of Marzia shows a rough road and setting, where the role of the primary care physician is a rather marginal figure, while the informal support received from acquaintances was decisive. Knowing how people reach, and who has sent them, the Mental Health Centre is undoubtedly useful because it highlights the visibility of the Centre for the community and the network of social and health services. Moreover, this aspect highlights the importance seeking help on your own, or the presence of people, formal and informal mediators, as well as the network of friends or acquaintances relatives. It is clearly known that a treatment strategy, regardless of its institutional legitimacy, consists in addressing all of the medical system resources through the use of practices, logic and symbols within the context of the suffering person. For Marzia, the her arrival at the Mental Health Service Clinic was part of a long, complex process which translated into an intermittent relationship that today involves moments of approach and detachment.

Starting from the evidence gathered from the area's residents and statements from the local ASL CSM [Public health care clinic/Mental Health Centre and Clinic] staff, we found that 60% of those who sought the mental health assistance went through Rome's City Social Services, while a smaller percentage went there on their own, helped by local support networks, while only a fraction thanks to their primary care physician. In the latter case, the dominant tendency on the part of the users interviewed is to interpret being sent the Mental Health Centre as neglect and disregard on the part of the referring physician or GP. As it often happens when pain becomes chronic, doubt is cast on the authenticity of the experience and the patient, who by not encountering a solution to suffering, tends to feel disregarded or abandoned. *"No one has ever helped me. Here we are all in bad shape, and what can I say to a doctor? At best, they tell you to go see a social worker, but if you think you have a disease that's not where you are looking for help. You ask all around to find people who have the same problem and go down so many roads".* Chronic pain involves the inevitability of failure. Communication between different explanatory models finds consistency where the sufferer interprets the words of the doctor in order to better understand the disease from which he or she suffers, and the therapist listens to the words of the patient in order to identify the disease. However, if the patient comes from a context such as the residence in which *"we are all in*

bad shape", the patient will feel labelled as subject at risk, a loather, depressed and hopeless, in such a way as to read a referral to local social services as a form of de-legitimization of the pain felt. As it often happens in the field of mental health in many other narratives collected in this area, the causes of the malaise are sought mainly through the exploration of the body, because the suffering must have a location, and description of a psychological malaise cannot explain the intensity of the suffering endured. Physical symptoms are those that are felt first, and those who are of greater concern: "*the idea of depression, for me, was not enough to explain my illness*". Nevertheless, in the sample observed the use of primary care seems to represent only a marginal factor, while self-referral is used more frequently and are structured on three levels. In the first level, reference is made to the request for help addressed to residents of the area who have worked or are working in any health care setting. It's not important what role they play, as long as they belong to an environment recognized as therapeutic—they could be people who handle cleaning of hospitals or people working in the field of care for the elderly or other related fields. This category of persons is often elected by the sufferer as a source in order to address a course of treatment. A second level of support in the field of self-referral (going there on one's own) is seen in people who have had a therapeutic relationship with the service, which serve as mediators between the patient and the Centre and are considered by respondents in the interview as those who offer advice on the based on personal experience. These figures, tested within the territorial mental health in some Italian regions and identified as social facilitators, encapsulate the meaning of initiation to a path of suffering and membership in a therapeutic institution. The third level identified in the field regards community involvement in the process of care and addressing those who are suffering. This level, which is a rather limited phenomenon and generally does not involve people who are subject to social withdrawal, is a mobilization turned against those who disturb or show serious health problems that clearly involve the body. In the residence, in order for Community support to be activated, it is necessary that meets specific standards of borders that do not allow intrusion or interference in the private sphere. Issues regarding couples, for example, despite being outsourced, and experienced in the public sector, do not arouse any intervention from services in the area. This is the case of a great deal of pain suffered by a woman we'll call Costanza, who was been abused by her partner for about one year. Neither she nor her companion was pushed to ask for help, even though both showed obvious signs of physical pain, and episodes of violence and self-harm had occurred in housing's common areas.

No one ever stepped in to help; yet the house's walls are very thin and you hear the screams. A. Not even friends ever come to help him when he went crazy and said he wanted to kill me and kill himself; one of them lives right here in front of us. I was the one who went to look for a lady who lives here and who had the same problems. With her I started a long ordeal that then, after a year, took me to Social Services, the CSM [Mental Health Centre,] and filed a formal complaint. But nobody helped him. Well, he wasn't even aware that he was sick, because in those moments he believed that everything he did was right. He had his reasons at the time. His friends, who today I meet on the stairs, look at me disgusted because I went to the cops, and now

I want to get out of here. No one understands that I have also done this to protect my children! They are all small and the house we live in is tiny … it was not right that they experienced those situations. In any case, I will not ever get out of this situation, and nor will my partner. We are now scarred for life!

Costanza is now alone inside the residence and is often verbally attacked by residents, because along with her friend, she involved local institutions to resolve a private matter [13]. This story, which will be detailed further in the text through the testimony of her husband Alessandro, allows us to approach the understanding of the role played by the various institutions within the setting of local treatment.

As touched on in the previous paragraph, the percentage of referrals and access in the field of mental health is very often due to Social Services. In the case described above, discrimination directed at Costanza regards use of the police and not that of Social Services. This factor introduces an important aspect on the degree of tolerance that the Town Hall Service has succeeded in stimulating within the cultural context of the residence. Specifically speaking, Social Service for minors, since 2000, has developed an approach they call "relational systemic approach", which includes the concept of "family as a resource" within those interventions aimed at the residential population.

Once we had started working in 2000, we began a project that today has shown good results in the population of the residence (buildings). From the prejudice that labelled social workers as "those who take children away", we worked through complex levels of intervention. For example, we start from the financial contribution granted to people who come to us for help, and slowly, after a max of two years, the granting this assistance-tool is cut off. The family begins to take a more complex level of concern regarding, for example, their relationship with their children. So, we work with professionals who enter the domestic space of the family, and we increase their degree of understanding regarding internal dynamics. From this level, we move to dialogue with other services, such as local health clinic, and working on individual malaise, couples or the issue of parenting. This is how the population arrives at the Mental Health Centre. Municipal Social Service Professionals.

The professionals of the Mental Health Centre confirm the close link between the local people and the department for minors at Social Services in the path of access to health facilities. This situation, however, appears to be totally absent as far as adults without children are concerned. In this case, the communication between services is almost non-existent. As with Marzia, to prevail is the doctor look at the single that induces professionals to underestimate the social, cultural and economic aspects of illness and treatment. Biomedicine is indeed effective in treating various acute diseases, however it is not appropriate to deal with the structural and social problems that ravage those living on the margins of society. As shown in a study of the *Mental Health Department*, Laziosanità—ASP and the Department *Social and Community Psychiatry, Queen Mary University of London*, focused on the analysis of health and social care for people with mental health problems, within marginalized groups in the area of several European cities, many services openly stated their inadequacy in dealing with therapeutic interventions for socially-marginalized groups. In several interviews with mental health professionals, we see the impossibility, and difficulty,

in reaching certain segments of the population due to the fact that the complexity of the needs of marginalized people extends not only to the poor socio-economic conditions, inadequate housing and social isolation, but also lack of readily available information on health and social services.

Support of this scenario is also found in some of the data regarding the area in question, taken from epidemiological system of the Department of Mental Health of the local health clinic (ASL).

By way of example, from 1997 to 2015, users living in the complex who have turned to the local mental health services appear to be 3.8% of the total population, of which the highest percentage is female (65%). Since the diagnostic totals of the S.I.S.P. (ICD IX C. M.) used by the Mental Illness Department (DSM—local ASL) we find a high prevalence of neuroses (60%) and following, in descending order, affective psychoses, oligophrenia, addictions, schizophrenia-paranoid states, and organic psychoses.

Patients from the residence who were taken on for care or treatment from the different territorial services reach only about 10%.

Regarding the information above, specifically on the lack of social and health interventions that should see the integration of the different services, we should remember that every modern state should be equipped with a system of social protection defined by the four elements of competition: education, social security, assistance, and health. The mental, physical, and social health of people depends on individual variously-integrated responses and calibrated in relation to specific needs to be met. Not unexpectedly, large hospitals and tertiary-care clinics are of little use for those families who, much like the residence of the investigations, live in a single, unhealthy room and do not have enough money to eat. In essence, a good social security system must be based on the balanced development of all four of the elements listed above. A health care institution will hardly be able to function effectively in a context where the other aspects are reduced and insufficient. Indeed, the health care system will be forced to act on improper needs—such as long hospitalizations aimed at people without home care—using more and more resources and, worse still, using health care facilities for need not related to actual health care. Therefore, in short, a health system cannot be planned and managed if not within the social protection system of which it is part. If there is not a sufficient degree of security, care and education, no system can work, due to the fact that it would be forced to resort to more resources, making use of health care services for needs that have nothing to do with health.

Our working conditions, when we face the care of a patient from the residence, are really very complicated. Sometimes we do not assign a diagnosis to avoid the risk that the subject could be psychiatrically diagnosed, while we are well aware that the problems are socio-economic in nature. Or we are in charge of diagnoses in order to obtain economic benefits because the patient needs to get out of a situation. Or again, we find ourselves putting people in health facilities when the person absolutely needs assistance from social services. Professionals of the Mental Health Centre of the local ASL unit.

The legislative system in recent years has led to the strengthening of those cultures and administrative practices, operations and policies aimed at the active promotion of

"local" aspects, seen as the institutional political space for the development of social cohesion. This is the way they were defined, between the various institutions of the "territorial pacts [agreements] for Mental Health" aimed at setting-up policies and programs for local development aimed at social cohesion, environmental promotion, prevention-promotion and protection of mental health.

On a more general level, we can say that the current approach is aimed at solving problems related to prevention. However, this prevention, albeit considered on a whole, should be divided, even within a psychiatric hospital, in primary, secondary and tertiary care. Specifically, primary prevention is oriented to eliminate those factors that are judged likely to cause or contribute to the onset of mental disorders and that develop in the context of so-called primary institutions: family, school, and work. When you consider that the answers available for prevention programs are usually rather limited, it is clear that there is a difference between the positive intent and operational reality involving a complex situation like that of the Bastogi. This is not to say that simply with primary prevention we can eliminate the causes that underlie a disease. Such a view is pure utopia, especially when you consider that the nature of risk factors for mental health are attributable to structural forces, due to the fact that it relates to the political and economic organization of society.

Secondary prevention is seen as the set of measures and interventions aimed at reducing the prevalence of psychiatric cases, along with the average duration of mental disorders, through early diagnosis, effective treatment and the identification of those at risk. The reduction of prevalence, epidemiological measure in which covers all cases of reported disease (new cases and those already in treatment) in a given population, can in fact be obtained through the clear distinction of two types of interventions: one aimed decreasing the onset of new cases by means of a modification of the factors that determine or facilitate their beginning, while the other works to shorten the course of the disorders by means of a treatment that is as effective as possible. The first type of intervention falls in the field of primary prevention, while the second will have greater success, based on how early is put into place and the number of people to whom it is applied. The possibility to make an early diagnosis requires the identification of early symptoms from both the sufferer and those around him (family, friends, etc.)—and, above all, by the primary care physician. Early referral requires vast workings of health education and public awareness in terms of the recognition of the symptoms, as well as the elimination of the stigma attached to mental disorders. At this stage of secondary prevention, the primary care physician plays a central role, however, as reported in the first part of this paragraph, the primary care physician is almost never present in the therapeutic itineraries of end users and patients from the Bastogi residence.

The last tool supporting secondary prevention is found in the contact with the population at psychopathological risk. In practice, this means the identification of groups and individuals who, for reasons related to age, specific social conditions and problems related to the dominant culture, are more at risk than others, due to the fact that they are more exposed to the devastating effect of social issues. Based on this last aspect, we find tertiary prevention—aimed at reducing the degree of suffering, disability and social disability due to chronic mental disorders, while also promoting

the recognition, development and use of the functional capacity of the individual. Indeed, it is considered as a set of interventions and medical-welfare projects that works with the entire communities, or catering to chronic psychiatric patients as a general category.

Within the territorial context of the Bastogi residence, we can see the almost total absence of the different programs and contents in the "territorial pacts for mental health" and in the three levels of prevention described above. In this regard, we find an explanation in the two objectives contained in the sole memorandum of understanding (14 June 2012) that exists between the Social Services of the City Hall and the locals CSMs [Mental Health Centres]. The goals of the following protocol are: to Avoid duplicate interventions; to favour the identification of priorities, services, and resources to be used. Far from representing an institutional integration model that encourages the building of policies and programs for local development, reference to these two objectives only involves the management and organizational context of the resources of these Services.

The integration of services is completely lacking. Theoretically they are all ready, but in practice it does not do anything. When the town hall [city government] has no resources, it turns to us in search of a diagnosis that can start benefits, job placement assistance, and so on. In turn, we are accused of sending to the Town Hall psychiatric cases that should involve our resources, and not those of the municipalities. This accusation, however, does not take into account the fact that health services can pay structures and health interventions but not social work. Therefore, if we have a patient, who is using social services, we can only send him or her to a health facility. Local ASL Mental Health Centre Professionals.

The dialogue between these services, played mainly on issues unrelated to those concerning the states of health and disease in the individual, appears to highlight the power relations that arise from the conflictual coexistence of different institutions in constant trouble or disrepair due to periodic spending cuts carried out by the State.

As shown in Giorgia's story, the conflicts between the territorial services can greatly affect the course of treatment for individuals suffering from mental illness.

Giorgia

She is 60 years old. She has left behind a long period of time working as a prostitute. Today she is physically and psychologically debilitated. Due to obesity and related joint pain, she is not able to move independently, and therefore she has the same problem for work. She is alone and has no children. She has lived in the residence for several years. Her therapy began ten years ago when it turned to the social workers of the City Hall. She received subsidized economic support for about a year and then took part in work placement that ended after a short time because of her physical condition. Giorgia is unable to manage her condition and has hardly ever referred to her primary care physician in order to be able to fight the severe pain. "Once I went to a doctor who told me that I probably had thyroid problems and diabetes. I was supposed to do some tests, analysis, but I do not want to go around, to wait in line and everything else. So I do not even know what makes me sick." Social Services, after the attempts described above, decided to contact the local Mental Health Centre. "For years I've gone to the CSM [Mental Health Centre],

and sometimes I go back. Those people from the City Hall have advised me to go to them, because there was the possibility that I would get a check for disability, but it didn't happen. They gave me a diagnosis of depression and then started the request for disability, but they have failed to obtain it. I know very well that I'm handicapped. I cannot move, I'm always bad, I feel pain all over, but I was not given this blessed certificate … I'm asking myself why they could not accompany me to do the certification? By myself I can't, everything is difficult and tiring. I'm sure if someone had come with me to do all these things I had to do, at this point I would have what is mine. Instead they invited me to do the trips, to do this and that and pass me around from side to side. Social Services have stopped following me and now the CSM does not help me anymore. Sometimes they call me and I go with great difficulty, but then nothing." Giorgia is described by the professionals of the CSM as a non-cooperative patient, interested only obtaining the subsidy. This outlines an incomplete course of treatment where none of the services has taken account of the pain that torments and blocks the life of this woman.

4   Conclusions

In the narratives presented, we can find all the existential depth of the experience of uprooting caused by economic marginality, as well as all the repercussions of the vital sadness and the innumerable physical pain caused by daily activities and routes. Importantly, we also see all the biographical fractures that affect the perception of roles, gender, life cycle, material and symbolic violence.

Urban suffering is an interpretative category of the encounter between the suffering of the people and the social factory they inhabit. Therefore, this proves to be an extremely effective paradigm in order to shed light on the deficit of social capital and relational quality produced by those welfare policies that trap weak social agents in the meshes of temporary housing assistance and assisted living. Such a perspective would make it possible to frame the phenomena of the gentrification of the real estate market, the industrial crisis, the restructuring of work, the flexibility to tertiarization, the precariousness of the educational institution as forms of structural violence that are expressed in a daily violence that reinforces inequalities [14].

In the Bastogi residential area, the identity of belonging to the local community is determined by recognising oneself as a group made up of people living in conditions of strong economic hardship, high dependence on institutions and poor integration into the world of legal work. There is a sense of belonging that does not exclude the frustration and suffering experienced in recognising oneself as belonging to a specific social marginality. In the street culture of the Bastogi residence, which permeates the behavioural codes of many young people and local adults, one can easily encounter opposing identities representing a proud rejection of social marginality and a defensive denial of one's own vulnerability. Here a closed horizon prevails around a suffering corporeality that progressively relegates itself to a situation of isolation. From here, the individual finds no other way out than that of painful

emotions. Job disappointments dot the collected narratives, and their attempts to leave illegal work or stay within the conventional labour market tend to find painful resistance, leading eventually to self-destructive behaviour. This resistant culture does not define a coherent and conscious universe of opposition, but rather a spontaneous archipelago of practices that in the long run have grown into opposing lifestyles and behavioural patterns. In a tragically ironic manner, illegality pushes these individuals into a lifestyle characterized by violence, abuse and inner fury. Consequently, in an intrinsically contradictory essence, street culture rests on the self-destruction of its members, or on their complete withdrawal from any social reality, including those that are internal, within the context of their homes and neighbourhood.

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