LONG-TERM COURSE IN SCHIZOPHRENIA: PREDICTING CHRONICITY FROM A 15-YEARS FOLLOW-UP OF AN INCIDENCE COHORT

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Patients suffering from a first life time psychosis of non-affective type were in 1978 included in a 3-year follow up study and investigated again in the WHO coordinated multi-center International Study on Schizophrenia (IsoS) including patients from various centers in Europe, Asia and North America. The Dutch study completed the 15 years follow-up in 1993 and found out that 19 patients (23.2%) of the total cohort of 82 patients could not be contacted anymore, due to suicide (11.0%), migration abroad and privacy regulations (6.1%) and refusal (6.2%). The remaining 63 (76.8%) patients could more or less be fully interviewed. Data on course of illness, symptomatology and social functioning, and needs for care were collected in a standardized way by means of the PSE-10, the Disability Assessment Schedule (WHO-DAS), the Life Chart Schedule, and other for this project tailor-made schedules. Course of illness and functioning [1,2] will be described in terms of number and length of episodes of psychosis, incomplete (negative syndrome vs neurotic syndrome) and complete remission, and analyzed in relation to spells of in- and outpatient treatment or no treatment. Chronicity and (time to) relapse after each consecutive episode has been analized by means of cox-regression with predictor variables at time of onset of first psychosis (age, sex, education, marital status, premorbid functioning, employment, onset of psychosis, initial diagnosis schizophrenia vs other reactive psychosis). The predictive power — in terms of time in psychosis, partial or full remission — of demographic, illness and treatment variables at onset of the illness was very limited. Insidious onset and delays in mental health treatment are 'risk' factors, predicting a longer duration of first or subsequent episodes. The factor of mental health treatment is probably subject to change because an early warning and intervention strategy could prevent too much damage and further deterioration. Our data support the need for an adequate relapse prevention programme as a priority for our mental health services.

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S32. Mental hospitals — a thing of the past

Chairmen: G Harrison, M Ruggeri

THE NEED FOR MORE PSYCHIATRIC BEDS: A NEOALIENIST PERSPECTIVE?

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The status of psychiatry as a medical discipline is currently low. Progressive bed closures make it increasingly difficult to deliver service in many areas and have led to widespread but unacknowledged splits among professionals over their personal philosophy of care. Bed closures have been achieved partly through the demonisation of institutions and the perpetuation of myths such as "institutionalisation", the notion that catchment area services can run safely and effectively without beds, and cost savings. Professional attention is now focused on the reality of unlimited responsibility for patients in the community following the introduction of CPA, Supervision Registrars, and the threat of Inquiries following untoward incidents. The question remains over whether a "vision" of community psychiatry can ever be successfully achieved in the context of inadequate and inequitable resource allocation, and heightened but unrealistic expectations of performance from health care professionals.

It is argued that there should now be an open acknowledgement that a large increase in the number of psychiatric beds is urgently needed. Beds should be allocated according to measures of true need. This argument is supported by a review of the literature and recent research findings in secure forensic facilities. A substantial subgroup of patients are identified with conditions which are not readily responsive to contemporary psychiatric treatments and whose challenging and dangerous behaviours cannot be tolerated in the community. Many require prolonged hospitalisation or periods in caring, highly supportive, institutional settings during their lifespan.

IN DEFENCE OF COMMUNITY *AND* INPATIENT CARE

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The debate and actual choices in psychiatry as to the locus of psychiatric treatment seem to be dominated by ideology rather than by research-based arguments. Randomised studies comparing inpatient treatment to 'community alternatives' (day treatment, home care) indicate that both modalities are needed. Two randomised studies [1,2] have explicitly assessed the degree of feasibility of *day treatment* for unselected *(sub) acute patients* referred for inpatient treatment. Zwerling and Wilder concluded that no more than 39% of their study group could be entirely treated in day hospital. Kluiter et al. found that 61% of their patients could not do without a bed for a substantial period. Five more randomised studies [3–7] compared day treatment and inpatient treatment. In all five studies patients were a priori selected with respect to their being suitable for day treatment. Between 85% and 62% of the patients were (had to be?) rejected for day treatment. None of the randomised experiments comparing *home care* with inpatient care indicate that *acutely disturbed patients* can do without the hospital [8–12]. The care offered in the experimental condition was usually intensive and frequent. Nonetheless the percentages of patients in need of the restrictiveness of an inpatient environment were substantial. In all studies however the average stay in hospital could be strongly reduced, demonstrating that home care and inpatient care can constitute a strong combination. Results from a recent open study by the author show that longstanding home care, closely linked to a hospital, for *chronic patients* is paradoxically far more effective in reducing the number of beddays than stand-alone community care. This finding is in accordance with the results found by Tyrer et al. [13]. (To our knowledge no randomised studies are published covering latter topic.)

The evidence presented strongly suggests that is unwise to abolish inpatient care. And why then abolish (good) mental hospitals where the expertise is?

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HOSPITAL CARE: FROM SUN TO MOON

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Mental health services have shown a dramatic shift from being centered around hospital beds to a diversification into many community based provisions, including 24 hour care. This has meant a change in many aspects of hospital care, whether structure, function, staff or patients.

Structurally the number of beds have been reduced very fast over the last decade, and several mental hospitals have closed. Instead, beds are based in smaller units, sometimes in District General Hospitals, sometimes in innovative community settings.

Functionally hospitals are no longer the centre of the service, instead they offer support to community teams. The greater awareness of outcome of hospital stays and its associated cost has meant a drive towards reduction of bed use by setting up community teams. Several British studies have shown that this strategy only works if teams select their clients well, and have control over admission and discharge.

If effective, this strategy leads to a concentration of people with the most severe problems in hospital for short periods. Patient mix is very difficult to care for, with demoralising effects on staff. Numbers and skills of staff have to be increased to deal with this, threatening to nullify any savings. The threat of a 2 tier system, hospital and community staff, also needs addressing.

Finally, patients and carers prefer community care and dislike hospital admissions, provided support in the community is available. However, places of safety are necessary to protect society and patients alike.

The conclusion is that the shift in care requires shifts in thinking. Community care is not simply exchanging beds for teams, but implies a major change of functions for every element of the system. This in turn demands a rethink of staff roles and training of agencies and professions, from the top to the bottom.

COMMUNITY-BASED PSYCHIATRIC CARE WITHOUT BACK-UP FROM THE MENTAL HOSPITAL. A LONG-TERM EXPERIENCE

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The aim of this paper is to present data, collected in South-Verona, Italy, on a long-term experience of provision of community-based psychiatric care without back-up from the mental hospital, which is gradually being dismantled. This was achieved, according to the Italian psychiatric reform, by means of a block on all admissions to mental hospitals after December 1981, without encouraging abrupt de-institutionalisation. A comprehensive and well integrated system of care was implemented in 1978 and is gradually developing since. It provides care (including in-patient care in a general hospital psychiatric ward where all admissions, both voluntary and compulsory take place) to all patients in at-risk population. South-Verona is a mainly urban area, relatively affluent and predominantly middle class, with a low migration rate. The total population is about 75,000 inhabitants. The South-Verona Community Psychiatric Service (CPS), includes a comprehensive and well integrated number of programmes and provides in-patient care, day care, rehabilitation, out patient care and home visits, as well as a 24 hours emergency service and residential facilities (three apartments and one hostel) for long-term patients. A Psychiatric Case Register (PCR), which covers the same geographical area of the South-Verona CPS, started on 31 December 1978 and has been operating since. Also private hospitals and other agencies in the larger province of Verona provide information to the PCR. Case register data as well as results of evaluative studies conducted in the last ten years will be presented. They show that in 1994, as compared with the year preceding the psychiatric reform, compulsory admissions decreased by 80%; moreover the use of psychiatric beds consistently decreased over time and the mean rate of occupied beds (both in public and private hospitals) per day in the last few years was 0.25 per 1,000 at risk. Since 1979 long stay patients (those who stay in hospital continuously for one year or more) are consistently decreasing, while long-term patients (those not long-stay patients who are continuously in contact, for one year or more, with some psychiatric service, not necessarily the same service or only one service, with a gap between two contacts never longer than 90 days) are steadily increasing. Data on clinical and social outcome in different groups of patients show that the South-Verona CPS meets the needs of severely disabled and most disturbed patients and suggest that it is possible to deal with the full spectrum of psychiatric morbidity within a community-based psychiatric service without back-up from the traditional mental hospital.

WHAT IS THE BEST WAY OF DELIVERING MENTAL HEALTH CARE TO THE SEVERELY MENTALLY ILL?

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Throughout most developed countries there is a revolution in the delivery of mental health care and this is seen most prominently for those with severe mental illness. The hospital, both as a place of refuge (asylum) and as a focus of treatment, is being replaced by other forms of care. This care is loosely described as community care but it is becoming recognised that this terminology is unsatisfactory as there are so many different types of community care, including the judicious use of hospital. The impetus for providing care outside hospital is often felt to be driven by economic rather than clinical pressures but as individual rights and choice become more widespread the social pressures to provide care which is non-institutional are likely to increase.

Studies of alternatives to hospital based psychiatry in Italy, the United States, Australia and the United Kingdom have demonstrated that assertive community based care for severe mental illness is at least as effective and uses fewer beds than hospital-orientated care, and is much preferred by patients. The best model for providing this care is that of a multidisciplinary team working closely together and sharing many of their roles (the skill-share model). The main reason why such a model is not adopted more widely is that training for community care is far behind best practice in the discipline.