Italian Psychiatry

SIR: Most articles dealing with Italian psychiatry in the past five years have considered the public sector side of psychiatric intervention, while omitting any comment on private practice (Mosher, 1982; Becker, 1985; Jones and Poletti, 1985, 1986; Tansella, 1985).

The regulated, public sector is carefully analysed by the above authors, but it may be helpful to underline a trend towards a further splitting of psychiatric practice. In the public sector there is an area, i.e. acute control/therapy, which can be considered as strictly medical (it includes psychiatric wards in general hospitals and mental health centres); now, a second area is under development, i.e. long-term assistance/surveillance, which is to a great extent de-medicalised. This area includes day hospitals and criminal psychiatric hospitals.

In the acute control/therapy area psychiatrists see acute patients who respond to treatment. In the long-term surveillance/assistance area there are mental health workers, most of whom are psychologists and sociologists, who stress their rehabilitation role in relation to patients' (possible) readmission into society. There is a long-running dispute between the two groups about the relevance of medical or sociological attitudes towards patients with mental disorder. Psychologists (who use the language of psychoanalysis and anti-psychiatry) are trying to take over, particularly in those regions, like Veneto, where there is already a good level of long-term assistance. The gradual worsening of public health standards, and the fact that psychiatry is poorly regarded in medicine, do not allow a debate and a comparison of results on purely technical grounds.

Moreover, in the private de-regulated sector psychotherapies and psychopharmacological treatment have flourished in an uncontrolled way. Here too the field is splitting asunder: the former being the province mainly of psychologists, the latter of psychiatrists. Patients have great difficulty in finding reliable help in the private sector, (although, of course, they pay for services) as recent legal actions testify. While admission to private clinics is still limited (at least in Northern Italy), such interventions are likely to increase because of scant facilities for in-patients in the public sector. A recent analysis (CENSIS, in press) shows that among five clusters of public services only one is judged as being efficient, and this is limited to certain regions only (Toscana, Umbria, and some areas of Veneto).

The public sector is therefore supported by the private sector, according to that type of mixed economy which allowed the Italian economic miracle, but which for psychiatry continues to raise serious doubts about any future improvement in standards.

ANTONIO A. RIZZOLI

Ospedale Psichiatrico
Marocco, Via Marocchesa 18
Venezia, Italy

References

CENSIS (in press) Rapporto conclusivo di indagine sul censimento e analisi dei servizi psichiatrici. *CENSIS*.

BECKER, T. (1985) Psychiatric reform in Italy. How does it work in Piedmont? *British Journal of Psychiatry*, **147**, 254–261.

JONES, K. & POLETTI, A. (1985) Understanding the Italian experience. *British Journal of Psychiatry*, **146**, 341–348.

—— & —— (1986) The Italian experience reconsidered. *British Journal of Psychiatry*, **148**, 144–151.

MOSHER, L. R. (1982) Italy's revolutionary mental health law: an assessment. *American Journal of Psychiatry*, **139**, 199–203.

TANSELLA, M. (1985) Misunderstanding the Italian experience. *British Journal of Psychiatry*, **147**, 450–451.

Latitude and Affective Disorders

SIR: I am interested in the effect of latitude on the expression of the genetic trait for bipolar disorder. Inspection of a world atlas highlights the relatively few English speaking communities within the tropics. Having practiced in Mackay, Northern Queensland, for four years, I am sure that chronic mania is considerably commoner than in the temperate latitudes, e.g. London, where I previously trained and worked.

My impression is of a 'shift to mania' in people who have the genetic diathesis for bipolar illness. I see less chronic depression (although that must be a tenuous observation) and a striking increase in the severity and duration of mania. Hence, chronic mania and manic stupor are increased. I would be interested in comments on this from those in various different latitudes, especially colleagues in Hawaii, which is equivalent in latitude to Mackay but in the Northern hemisphere.

It may be helpful if I put an order of magnitude on the occurrence of chronic mania (my *ad hoc* criterion for chronic mania is a minimum duration of 6 months, but most of the patients have illnesses of at least a year's duration). I have seen a dozen cases in the first four months of this year (the catchment area I deal with has a population of approximately 100 000). Included in those dozen cases would be two of manic stupor, or at least partial stupor.

It would be interesting to know if anyone can elucidate the possible connection between this apparent increase in the incidence of mania in the tropics and the old expression, "going troppo".

P. K. GILLMAN

P.O. Box 183
Mount Pleasant
Mackay
Australia