

**Results:** The mean ( $\pm$  SD) global IQ scores were  $118 \pm 17$  in the children of mothers who received a tricyclic antidepressant drug,  $117 \pm 17$  in those whose mothers received fluoxetine, and  $115 \pm 14$  in those in the control group. The language scores were similar in all three groups. The results were similar in children exposed to a tricyclic antidepressant drug or fluoxetine during the first trimester and those exposed throughout pregnancy. There were also no significant differences in temperament, mood, arousability, activity level, distractibility, or behaviour problems in the three groups of children.

**Conclusion:** In utero exposure to either tricyclic antidepressant drugs or fluoxetine does not affect global IQ, language development, or behavioural development in preschool children. (N Engl J Med 1997; 336: 258–62)

### S39-4

#### THE PHARMACOLOGICAL TREATMENT OF PREMENSTRUAL DYSPHORIA

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Five to ten % of all women of fertile age experience a severe form of premenstrual dysphoria (PMD) that markedly reduces quality of life and for which an effective treatment is highly warranted. It has frequently been suggested that a reduction in brain serotonergic neurotransmission may lead to irritability, depressed mood, and increased carbohydrate craving; since all these symptoms are prominent in women with PMD, the hypothesis that PMD may be related to serotonin is not farfetched. Supporting this concept, five different serotonin reuptake inhibitors (SRIs) have now been shown superior to placebo for the treatment of PMD (clomipramine, fluoxetine, paroxetine, sertraline, and citalopram); in contrast, the noradrenaline reuptake inhibitor maprotiline is not effective. The onset of action of SRIs is much shorter when used for PMD than when used for depression; we have hence obtained an excellent symptom reduction in PMD subjects by intermittent administration of clomipramine or citalopram in the luteal phase only. Further support for an involvement of serotonin in PMD is gained by preliminary trials suggesting that the 5HT<sub>1A</sub> agonist buspirone, the serotonin releasing agents fenfluramine and mCPP, and the serotonin precursor tryptophan may all reduce premenstrual complaints.

A role of sex steroids for the pathophysiology of PMD lends support from the fact that the symptoms may be reduced by ovariectomy or by administration of ovulation inhibitors. The importance of estradiol and progesterone for the onset of premenstrual complaints will be discussed, and an hypothesis suggesting that PMD is related to a slight hyperandrogenicity causing a reduction in serotonergic neurotransmission will be presented.

## SEC40. Is the mental hospital still needed?

*Chairs:* AH Mann (UK), L Singer (F)

### SEC40-1

#### THE HISTORY AND DEVELOPMENT OF COMMUNITY PSYCHIATRY

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Over the last 150 years, the history of mental health services can be seen in relation to 3 periods.

Period 1 describes the rise of the asylum between about 1880 and 1950; Period 2 is the decline of the asylum from around 1950 to 1980; and Period 3 refers to the re-forming of mental health services since approximately 1980. We locate these trends within a new conceptual framework, the matrix model, which includes two dimensions, the geographical and the temporal. The first of these refers to three geographical levels: (1) country, (2) local and (3) patient. The second dimension refers to three temporal levels: (A) inputs, (B) processes and (C) outcomes. Using these two dimensions we construct a  $3 \times 3$  matrix to bring into focus critical issues in the history of community mental health services. In terms of the geographical dimension, we describe a process of decentralisation, with a move from the country/regional level to the local level of service provision, and more recently, in the third period, towards specifying individual treatment and care within the local service. In terms of the second dimension of the matrix model [inputs, processes and outcomes], we suggest that the differential emphasis between the three historical periods is even more emphatic. Although we consider that outcomes are the most important aspect of services evaluation, these outcomes can only be interpreted in the context of their prior temporal phases, namely inputs and processes.

- (1) Tansella M & Thornicroft G (1998) A Conceptual Framework for Mental Health Services: the Matrix Model. *Psychological Medicine* (in press).
- (2) Thornicroft G & Tansella M (1999) Re-forming mental Health Services, Cambridge; University Press, Cambridge (in press)

### SEC40-2

#### TIME TO SLOW DOWN THE DECENTRALIZATION PROCESS?

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The process from institutionalized to deinstitutionalized psychiatry has taken place in Western Europe during the last 20 years. The change has been characterized by ideology and to a minor degree empirically based health service research and epidemiological research.

Seen in retrospect one could have wished the changes to happen in a more moderate way

1. these could have been carried out in 40–50 years and not rushed through in 10–20 years.
2. the decentralized treatment and service facilities could have been build up before the closing down/ the drastically reduction of the existing institutions.

No doubt, the deinstitutionalization has been a benefit for a good deal of the mentally disordered, however, a row of negative indicators suggests that not all of the most severe mentally ill are winners:

- increasing number of criminal mentally ill
- increasing SMR among the psychotics
- increasing use of coercion in the wards
- increasing number of occupied beds in the wards

With Denmark quoted as an example it is documented that for some patient groups the decentralization might have gone too far and in any case too fast. There are hopes of a more positive development in the next few years, gauged by a braking of the disintegration of institutions, establishment of others, respect for mentally illnesses as brain diseases, and by specialization and centralization of treatment functions.

### SEC40-3

#### QUALITY OF LIFE FOR PATIENTS IN THE COMMUNITY

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Institutionalisation, depersonalisation and removal of the psychiatric patient from his social network were the characteristics of asylum psychiatry at the turn of the last century. One hundred years later, de-institutionalisation, personalization and re-insertion of the patient into the community are the declared aims of official mental health policy. What is the difference for the patient's quality of life? Quality of life is not yet a clear and well-defined concept, although it has an intuitive appeal to most people. Who would not like to experience a good quality of life? If quality of life is equated with the fulfilment of needs, a first approximation would be to use Maslow's hierarchy of human needs, starting with the most basic physiological needs for food and shelter and leading over belonging needs to psychological and finally self-actualization needs. No doubt, asylum psychiatry has fulfilled the most basic physiological needs, but has neglected psychological and self-actualization needs, especially some of the most valued needs, that for autonomy and for being part of society. Community psychiatry, on the other hand, tends to fulfil the latter needs, often - as it seems - at the expense of the more basic physiological needs, as the many homeless people on our streets seem to tell us. Recent research, however, shows an astonishingly high degree of satisfaction among patients moved from the hospital to the community, even if material life circumstances seem less satisfying to an ordinary person. Autonomy and participation in community life, although still limited for many patients living in the community, are higher valued by the majority of patients than the material security of the hospital environment - at least once experiences could be gathered with living in the community. A limiting factor for gaining full autonomy and participation in community life is not so much the residual disability - due to the specific mental disorder or due to the effects of institutionalisation - but what can be called the "stigma dilemma": Perceived stigma is a strong determinant of subjective quality of life, as recent research has shown. As a rule psychiatric patients living in the community receive help in terms of treatment and material assistance by declaring themselves as patients and accepting the role of the mentally ill. At the same time, accepting this role carries a societal stigma with it, which excludes these patients from normal life, from "being part of us". The dilemma "help and stigma" or "no help and no stigma" would already be impossible to solve for a healthy person. We have to be very creative in order to overcome this major obstacle to improving the quality of life of patients in the community.

### SEC40-4

#### THE IMPACT OF COMMUNITY CARE UPON FAMILIES

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More than a century ago institutionalization of psychiatric patients was started. Arguments for this were not only the possible benefits of care and treatment for the mentally ill. For this hospitalization movement relieving families and protecting society were just as important. Nowadays most countries try to find a balance between caring for patients at the one hand and caring for the society, and more in particular for family members, at the other. We aim at good community care.

During the last ten years we have been studying the consequences of being a family member or close relative of someone with a mental disorder. We developed the Involvement Evaluation Questionnaire, a 78-item instrument to measure the impact of mental disorders for relatives or caregivers. With this instrument we studied the impact of caregiving for families of patients with schizophrenia (N = 680) and depression (N = 260).

For both groups of families factor analysis showed 5 factors: tension, supervision, urging, worrying and finances, and a totalscore with an alpha of .90. In this paper the influence of patient, family member and interaction characteristics on the amount of caregiving consequences will be discussed for both patient groups. Different initiatives to reduce family burden will be shown especially in relation to developments in Dutch community mental health care.

### SEC40-5

#### DEINSTITUTIONALISATION AND SCHIZOPHRENIA IN FINLAND. RESULTS OF THE DSP-PROJECT

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Finland has experienced one of the most rapid psychiatric deinstitutionalisation processes in the whole world. Since 1980, the use of psychiatric beds has decreased about two thirds. The effects of this process was studied in a national study project of the Discharged Schizophrenic Patient by three representative samples of schizophrenic patients discharged from Finnish mental hospitals in 1982, 1986 and 1990. In all, 3 300 patients were studied and followed for three years.

The in 1990 discharged schizophrenic patients were older, more disturbed and had been ill for longer time than at the beginning of the 1980s discharged patients. The use of out-patient care increased and that of hospital care decreased but because of the increased residential out-patient care the total amount of residential care did not change during the study period; re-admissions to hospital increased, however. In the patients with a long duration of illness the increase of re-admissions was exceptionally high; they also seemed to be losing their share of the residential out-patient services. The patients discharged in 1990 were more often living alone than the patients discharged earlier. However, their housing conditions were comparable with those of the general population and homelessness was rare. At the follow-up, the patients were more satisfied with their life than at the discharge.

On the whole, the deinstitutionalisation process seemed to have proceeded fairly successfully from the point of view of the psychiatric treatment system. It proved to be able to re-direct and use the resources available more effectively and modify the structure of services according to the changing needs of patients discharged from hospitals. The discharged patients had found rather good