people from pneumonia consequent upon prolonged bed-rest following a fall resulting in a broken leg are technically 'violent' (coded E880—fall on or from stairs or steps; E884—fall on same level from slipping, tripping or stumbling) and must be reported. Some coroners do not hold inquests into such deaths unless the fall occurred in a hospital or old people's home.

A further limitation applies to the place of death. This coding is hopelessly unreliable as a source of information on in-patient deaths because:

i. The code indicates the place where death was certified—not where the event leading to death, or in fact the death itself occurred. (Deaths are not always recorded as 'Dead on arrival at ... Hospital' but often recorded as 'Died in ... Hospital' when resuscitation techniques have been unsuccessfully applied before certifying death);
ii. Deaths in general hospital psychiatric units are designated as 'NHS non-mental' deaths;
iii. In-patients who are transferred from mental hospitals to intensive care units in general hospitals are recorded as 'NHS non-mental' deaths;
iv. Psychiatric or mental hospital in-patients who die after absconding are recorded as dying 'at home' or 'elsewhere'.

Thus it is impossible to assess the number of psychiatric or other in-patient deaths from OPCS statistics on the place of death, and the number classified as 'NHS—mental deaths' must be a minimum.

Conclusion

It is possible, using information generated by the statutory Death Registration procedure, to identify all persons resident in a particular area who have died from a specific cause of death during a specified period with minimum recourse to coroners' records, and subsequently to determine which of them have been psychiatric patients prior to their death. There are four source points (Table I). Table III gives an inventory of the information available from each source. A list of publications of use in making maximum use of the coded information is as follows:

Report of the Committee on Death Certification and Coroners (Brodrick Report). Cmnd. 4810. HMSO, 1971.

Population and Health Statistics in England and Wales. OPCS, 1980.

Area Code for Recording Place of Residence and Place of Birth. OPCS.

Death, Layout of Primary Record, 1973; and *Layout of Primary Death Record with Multi-Cause, 1976–78.* OPCS via Regional Health Authority.

Topographical Arrangement of Registration Districts and Sub-Districts. OPCS via Regional Health Authority.

The Italian Experiment

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In the beginning of the 19th century Italy was in the forefront of psychiatric reform. The question as to whether it was Chiarugi (1759–1820) or Pinel (1745–1826) who was the first to unchain patients in mental hospitals has remained unanswered. With the death of Chiarugi, however, the age of enlightenment, which he had heralded, faded and conditions in Italian hospitals reverted to their former state.

There were no significant changes until 1904 when a Mental Health Act was passed in Parliament, but this was aimed at the protection of Society rather than treatment of the individual. Mental hospitals remained large and provided mainly custodial care: they were inexpensively run and the old provincial administrations were only too ready to admit those who could not cope with life outside hospital and needed asylum.

In the early 1960s in a University Department of Psychiatry which I visited, patients were still tied to the bed by wrist and ankle straps and, some years later, when I questioned the necessity for the same measures in a large provincial hospital, I was told by the Superintendent that physical restraint was less harmful than chemical restraint in the treatment of disturbed patients! Yet in a purpose-built psychiatric unit of another University Psychiatric Department, a mere hundred miles away from that same hospital, conditions were very different and the Unit compared favourably with some of our own more progressive departments. There was, in other words, a great difference in the quality of care in mental hospitals between regions, depending on the attitude of the provincial administration as well as on that of the psychiatrists working in them. It was generally accepted that hospitals in the Northern half of Italy were much more progressive than those in the South.

In the late sixties there were some 100,000 patients in mental hospitals in Italy. Between 1968 and 1978 marked changes occurred in the attitude of society towards the mentally ill and the man largely responsible for this was Dr

Franco Basaglia from Gorizia. Like Chiarugi before him, Basaglia was a visionary, although at times a controversial figure. Some members of the College may well remember meeting and clashing with him on the last study tour of Italy. Basaglia's missionary zeal spread from his own province to the rest of Italy and his enthusiasm was communicated to psychiatrists, sociologists, left-wing politicians and administrators. Basaglia talked of the need to rehabilitate the patient, to restore his dignity and emphasized the need to help him to return to his normal home or work environment in which treatment, if needed, should be continued. And society took notice: community services were set up, out-patient facilities extended and hostels projected and built. As a result of such changes, more radical in the more enlightened provinces, the number of psychiatric in-patients fell from 100,000 to little more than 50,000 between 1968 and 1978. Some regions lagged behind and therefore a new legislation became a necessity. Not surprisingly, Basaglia was its architect, but unfortunately he died soon after the new Law was passed.

The new Law ('la legge 180') was produced and passed precipitously on 13 May 1978 by both houses of Parliament without, as an eminent Italian psychiatrist said, 'any meditated critical evaluation of the grave human and scientific problems on which psychiatric care must be based'.

Aims of the new legislation

The aim of the new legislation was the eventual abolition of the psychiatric hospital. The main points of the new Law were as follows:

1. No new hospitals were to be built and no old hospitals upgraded.
2. Existing hospitals were to be unlocked and the discharge of existing patients encouraged.
3. A distinction was made between patients admitted before 13 May 1978, who, if necessary, could be re-admitted to their old psychiatric hospitals, and new patients who were to be admitted to general beds of District General Hospitals.
4. No District General Hospital was to house more than 15 psychiatric patients at any one time.
5. Where compulsory admission was thought necessary, an order was to be signed by two doctors, countersigned by the Mayor of the town or city and it was the latter's duty to inform a specially appointed tutelar Magistrate whose function was to acquaint himself with the patient and to follow his progress. No compulsory admission could last for a period longer than seven days.
6. The responsibility for the care of psychiatric patients in hospitals was to be transferred from the provinces to the regions.

With the gradual abolition of the psychiatric hospital it was stipulated that psychiatric patients should be treated in their own environment and that responsibility for mental health care should be assumed by specialized district services. These would provide out-patient, day hospital and day centre facilities, domiciliary services, hostels, group homes, etc. The role of the psychiatrist extended beyond treatment to the integration and co-ordination of the various facilities available at any one time in any one place. A close link with general practitioners, schools, factories, etc., was considered essential.

From the outset there were many criticisms. Rigorous interpretation of the Law would imply that if a sixteenth patient were to arrive at a District General Hospital and need urgent admission, one would need to be discharged to make room for him, whether or not suitable discharge facilities were available.

Seven days were clearly not sufficient to treat an acutely disturbed patient. Moreover, the compulsory admission procedure was so cumbersome that it might take up to 48 hours to bring it into effect—too long a period in the case of a patient who was a danger to himself or others. A similarly cumbersome procedure was to be followed to ensure the prolongation of the order for a further period of seven days. Public opinion, although aware of the liberating measures of the new Law as well as the limitations of the old mental hospitals, was nevertheless concerned by the prospect of the eventual total closure of such hospitals, which were still considered by some to be society's defence against elements which it would not tolerate.

The new Law was applied differently in the various regions depending on cultural, political and socio-economic factors. From the less well endowed regions there was an exodus of patients to the more enlightened ones thus defeating the concept of 'continuity of care' which was expressed in the Act itself. District General Hospitals were soon filled with their quota of psychiatric patients and there was no room for patients who wished to be admitted informally or where it was thought that separation from their environment would be of therapeutic value to them. This necessarily resulted in the growth of private psychiatric clinics, often indifferently run, and available only to those with means. A critic writes: 'It is difficult to see how an Act regarded by the Communist Party as their brainchild could have led to a greater division between the haves and have-nots than that which existed already.' He and others had voted for the new Law to avoid a popular referendum which had been threatened at a time when the media, over a period of some months, had mounted a campaign exposing, with the help of photographs, films and videotapes, the appalling conditions prevailing in some of the most backward psychiatric hospitals. 'It reminded me'—the same critic says—'of Sunday preachers expounding on the subject of Hell!' Moreover, this campaign appeared to some as having the tacit approval of the Government anxious to transfer a heavy financial burden to local authorities.

When the old mental hospitals opened their doors, some 10,000 patients were discharged or discharged themselves,

leaving some 40,000 patients, most of whom were chronic psychotics or psychogeriatrics. The remaining hospital population has suffered considerably through the fact that the more ambitious doctors left for general hospitals or for the community, shortly to be followed by the more enlightened nurses. Thus the standard of care in mental hospitals now leaves much to be desired. Discharged patients have gone to homes and families which often did not want them or were not ready or prepared to accept them. Some have found their way to other chronic institutions, whilst others live rough and sleep in waiting rooms of railway stations. Some have disappeared altogether and, although statistics are not available, many are thought to have committed suicide and some have perpetrated crimes for which they are now in prisons, adding to the existing problems of overcrowding. Alcoholics have reverted to their old drinking patterns and are constantly giving problems to the police.

The plight of these patients is illustrated in a moving but somewhat emotional manner in Mario Tobino's most recent book, *The Last Days of Magliano*. Tobino, a psychiatrist, prolific writer and one of Italy's leading literary figures, is now 70 years old. He has spent most of his life in the mental hospital of Lucca amongst patients whom, he told me, he had come to love and regard as his own family over the years. The book is a bitter exposé of the consequences of the new legislation for his hospital and of the often tragic aftermath of the discharge of patients who were not ready to leave hospital. Tobino resents the attitudes of the 'so called reformers' and lays the blame for the present situation on the government, on society and on those sociologists and psychologists who have put theory before practice. Tobino, however, has his own critics and is accused by the more kindly of having an aesthetic rather than a scientific interest in psychiatry, while the more malicious allege that he has found in mental illness the inspiration for much of his literary work. Whatever his failings, there would appear to be much truth in what he says. Thus in October of this year, in the largest psychiatric hospital in Naples, a team of investigators described the conditions as 'frightfully inhumane'. The inquiry resulted in the arrest of three consultants, six nurses and the administrator of the hospital, all of whom are awaiting trial.

As I mentioned above, community services are often inadequate—some regions can only offer out-patients' clinics while in a wealthy province such as Milan, where there are some 7,500 psychiatric beds, there are only 170 hostel places.

The critics of the new Law are at pains to point out that only when such structures are firmly established can one talk of psychiatric reform as a practical possibility. It is also thought that the University Departments of Psychiatry, some of which are centres of excellence, and of enlightenment (but all of which were totally ignored by the Law itself) should be brought into the fray and should take part in community therapy and other research projects.

Vittorio Olcese, a member of the present government and a practical politician who had originally voted for the new Law but who has now become one of its more vocal critics, said in an interview given to a daily newspaper that the real problem was that the new Law, politically inspired, wants to deny the existence of mental illness. He admits that in the 1960s Basaglia 'shook the tree of the establishment and started a movement of reforms which was necessary and indeed inevitable'. The climate was favourable since psychoanalysis and psychodynamics were becoming increasingly more fashionable, but in the 1970s Basaglia's movement was transformed into something which was quite different. He and his followers maintained that the problem of mental illness could only be resolved by the advent of Socialism. Social reform was replaced by political Utopia. But as Olcese says: 'Utopia has never been known to resolve a concrete problem!'

Olcese is clearly an admirer of British institutions. He respects the English for proceeding in a reasonable way to the breaking down of the old psychiatric hospital and to the creation of smaller psychiatric units and community psychiatric services.

Proposed reforms

The Italian Parliament has now set up committees to study various reforms of the current legislation. The following proposals are some of those being examined.

1. Changes in the regulations regarding compulsory admission. Compulsory orders should be extended from 7 to 14 days and possibly, in order to avoid unnecessary delay in acute cases, it is suggested that a preliminary compulsory order for a period of 48 hours with the sole signature of the responsible medical officer and without judicial intervention, should be acceptable.
2. The number of beds for acutely ill patients should be increased. Changes in structure and function of psychiatric units are envisaged so as to fulfil a therapeutic rather than a custodial function. Whilst at the present time there is 1 bed per 25,000 members of the population, this should be increased to 1 bed per 10,000.
3. A suggestion has been made that patients should be taken to hospital by the police rather than by a community nurse. This has been highly criticized as not being in the therapeutic interest of the patient.
4. New patients should be separated from chronic or long-stay patients.
5. There should be expansion of out-patient and community therapeutic services, and in addition Mental Health Clinics should be set up each with a small number of beds for their crisis intervention teams.
6. New long-stay units of 180 beds should be created of which 60 should be designated for psychiatric patients.
7. Patients who do not recover from an acute illness within 30 days of what was originally a compulsory admission, should be transferred to medium-stay units. In these cases

further in-patient treatment for a period of one month should be obligatory.

8. University Psychiatric Departments must now be integrated into the existing pattern and must taken responsibility for District care and have the kind of administrative autonomy which is denied to other Mental Health Services. They should also be allowed to admit patients from other districts or regions thus restoring their status and power.

Supporters of the present Law feel that there is little wrong with it but that it has sometimes been wrongly interpreted and often wrongly applied. Some changes would seem to be inevitable, but whatever the outcome of the present deliberations, it seems important that the Italians should not go back in time and lose the impetus which has been created and which has put Italy once again in the forefront of the field of psychiatric reform.

Trainees' Forum

Contributions are welcome from trainees on any aspects of their training

Psychiatric Training in America: Two Initial Impressions

I: JANET LAWRENCE, Harvard University, Boston

The last year has been a fascinating one for me as a British medical graduate in many ways, constituting, as it did, my introduction to both American culture and a career in psychiatry. I have just completed my first year of a three-year psychiatric training programme (residency) at Harvard Medical School, roughly equivalent to a combined SHO and registrar training in Britain.

As I look back on the year, many of my experiences must have been comparable with those of British trainees at my level. The bulk of the first year's work was on a small acute psychiatric in-patient unit in the general hospital where my residency is based. Throughout the year, I also saw emergency-ward patients and gradually increased my out-patient load. Much of my time was also spent in didactic sessions and receiving four to five hours per week individual supervision, mainly on the patients under my care, from staff psychiatrists and psychologists.

In spite of the many similarities, there were sufficient differences that I was always reminded of working in a different cultural setting. The differences that were immediately apparent to me were those which I shall call the 'American scene'. Another large group of my impressions of the year might be included under 'economic factors'.

My first realization of medical cultural differences came just after the initial bewilderment of the first few weeks had worn off. We had watched a senior staff member interviewing a patient who had throughout the interview wisecracked at the psychiatrist, answered the psychiatrist's questions with questions about how the doctor would feel in the circumstances and had, to my British ears, sounded abrasive. My comment that he appeared to be hostile to the interviewer was met with much amusement. Apparently, American patients did not show the same kind of respectful, submissive stance towards their doctors as did British patients unless, of course, they really were hostile. Indeed, most British patients seen by American psychiatrists might seem pathologically compliant. This lack of formality was often also evident in working relationships, both in the considerable day-to-day communication between different levels in the hierarchy and in the encouragement of residents to provide feedback on the standard of teaching, through written assessments.

Other cultural differences became evident in the nature of my clinical practice. Recreational drug use, or at least past extensive experimentation, appeared to be ubiquitous among patients aged under 40 whom I saw last year. This was apparently not limited to the psychiatric population; a survey publicized by the media during this time found that 90 per cent of New York school children had experimented with drugs and a very high proportion was still using them.

Another difference emerged in the frequency of rape, probably both in terms of its incidence and its reporting compared to Britain, where during a six-month stint in a London emergency ward I did not see a single case. It was not uncommon to see two or three rape victims within a single night on call in Boston, admittedly in a hospital well known for its rape-counselling programme. This programme trained psychiatry residents, psychology and social work interns as counsellors in rape crisis they saw the victim on arrival in the emergency ward, prior to gynaecological examination. This provided an opportunity for the victim to ventilate feelings of anger, shame and often guilt, to be