PSYCHIATRY

THE STATE OF THE ART

Volume 7
Epidemiology and
Community Psychiatry

PSYCHIATRY
THE STATE OF THE ART

Volume 1 CLINICAL PSYCHOPATHOLOGY
NOMENCLATURE AND CLASSIFICATION

Volume 2 BIOLOGICAL PSYCHIATRY, HIGHER NERVOUS ACTIVITY

Volume 3 PHARMACOPSYCHIATRY

Volume 4 PSYCHOTHERAPY AND PSYCHOSOMATIC MEDICINE

Volume 5 CHILD AND ADOLESCENT PSYCHIATRY,
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Volume 6 DRUG DEPENDENCE AND ALCOHOLISM, FORENSIC
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Volume 7 EPIDEMIOLOGY AND COMMUNITY PSYCHIATRY

Volume 8 HISTORY OF PSYCHIATRY, NATIONAL SCHOOLS, EDUCATION,
AND TRANSCULTURAL PSYCHIATRY

PSYCHIATRY

THE STATE OF THE ART

Volume 7
Epidemiology and Community Psychiatry

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PLENUM PRESS • NEW YORK AND LONDON

Library of Congress Cataloging in Publication Data

World Congress of Psychiatry (7th: 1983: Vienna, Austria)
Epidemiology and community psychiatry.

(Psychiatry, the state of the art; v. 7)
"Proceedings of the VII World Congress of Psychiatry, held July 11–16, 1983, in Vienna, Austria"—T.p. verso.
Includes bibliographies and index.
1. Social psychiatry—Congresses. 2. Psychiatric epidemiology—Congresses. 3. Community mental health services—Congresses. I. Pichot, Pierre. II. Title. III. Series: World Congress of Psychiatry (7th: 1983: Vienna, Austria). Psychiatry, the state of the art; v. 7. [DNLM: 1. Community Mental Health Services—congresses. 2. Community Psychiatry—congresses. 3. Mental Disorders—occurrence—congresses. W3 W05385 7th 1983e / WM 30.6 W9258]
RC455.W675 1983 362.2 85-9546
ISBN 978-1-4684-4702-6 ISBN 978-1-4684-4700-2 (eBook)
DOI 10.1007/978-1-4684-4700-2

Proceedings of the VII World Congress of Psychiatry,
held July 11–16, 1983, in Vienna, Austria

A Division of Plenum Publishing Corporation
233 Spring Street, New York, N.Y. 10013

PREFACE

The purpose of the World Psychiatric Association is to coordinate the activities of its Member Societies on a world-wide scale and to advance enquiry into the etiology, pathology, and treatment of mental illness. To further this purpose, the Association organizes mono- or multithematic Regional Symposia in different parts of the world twice a year, and World Congresses dealing with all individual fields of psychiatry once every five or six years. Between these meetings the continuation of the Association's scientific work is assured through the activities of its specialty sections, each covering an important field of psychiatry.

The programs of the World Congresses reflect on the one hand the intention to present the coordinating functions of the Association and on the other to open a broad platform for a free exchange of views. Thus, the VII World Congress of Psychiatry, held in Vienna from July 11 to 16, 1983, was composed of two types of scientific events - those structured by the Association and those left to the initiative of the participants. The first type comprised Plenary Sessions, planned by the Scientific Program Committee, and Section Symposia, organized by the WPA sections; the second embraced Free Symposia, free papers, video sessions, and poster presentations prepared by the participants. Altogether, 10 Plenary Sessions, 52 Section Symposia, and 105 Free Symposia took place, and 78 free papers and poster sessions and 10 video sessions were held.

The editors of the Proceedings of the VII World Congress of Psychiatry were immediately faced with two major problems, namely how to deal with such a great number of presentations and how to present them to the reader. The only way to solve the first difficulty was to restrict the Proceedings to Plenary Sessions and Symposia. The second obstacle was surmounted by grouping the Plenary Sessions and Symposia according to their scientific content, which meant waiving the chronological order of the Congress. In order to achieve reasonable uniformity in the lengths of the volumes, it was not possible to devote each of the eight books comprising the Proceedings to a single theme. Nevertheless, we hope that the final arrangement will enable colleagues interested in only certain subjects to restrict their purchases to the

particular volume or volumes of their choice. The Proceedings in their entirety, however, represent a complete and comprehensive spectrum of the current areas of concern in psychiatry - the state of the art.

We are greatly indebted to our colleagues Rainer Wolf and Kenneth Thau. Their untiring efforts made the publication of these Proceedings possible.

Peter Berner

Secretary General, WPA
at the time of the VII
World Congress of Psychiatry
President, Organizing Committee
VII World Congress of
Psychiatry
Chief Editor, Congress Proceedings

ACKNOWLEDGMENTS

First and foremost, we should like to express our sincere appreciation to all colleagues whose scientific contributions comprise the content of these Proceedings.

We should also like to thank the immediate administrators of the VII World Congress of Psychiatry (Congress Team International), as well as the staff of the Vienna Secretariat of the World Psychiatric Association, for their collaboration in the compilation of this publication.

We should finally like to explain that, for technical reasons connected with the actual printing process, it has not been possible in every instance to eliminate minor typing errors.

Various reasons also prevented the compilation of all chapters in exact conformity with the presentations as contained in Plenary and Symposium Sessions.

Despite these problems, we hope that our aim to structure the content of the individual volumes as clearly as possible has met with an adequate measure of success.

INTRODUCTORY REMARKS

The World Psychiatric Association was born out of the Organizing Committee of the World Congress of Psychiatry. The first World Congress, held in Paris in 1950, was an event of the utmost importance. For the first time, psychiatrists of the whole world met to exchange their ideas and experiences and to promote the progress of our specialty. It later became obvious that such large congresses, convening every five or six years, needed to be complemented by a more permanent organization and by more frequent meetings smaller in scope and of a more specialized nature. The national psychiatric societies decided on the creation of a World Association which could assume all the responsibilities connected with such a complex task. I had the honor to be elected President of this Association at the VI World Congress in Honolulu and to hold this responsibility for six years until the advent of the Vienna Congress.

Whatever the importance of the various functions of the WPA, the organization of these World Congresses has remained its major task. It has become fashionable to criticize World Congresses because they attract too many participants, because the scientific presentations are not always of the highest quality, and because the multiplicity of the subjects discussed in simultaneous sessions obliges the participants to limit attendance to only part of the entire program. Some of the criticisms may be justified, but the fact remains that such congresses fulfill an important function. The majority of the psychiatrists of the world are not highly specialized research workers but practitioners. Many of them live in countries where they are relatively isolated and where there is little opportunity for scientific interchange. The World Congresses, by presenting not only the latest technical discoveries but also general surveys through leading specialists in the different fields of psychiatry, allow every participant to keep abreast of the state of the art. There is no better opportunity to become acquainted with developing trends, and personal experience of this type cannot be replaced by the reading of scientific journals. Of course, the value of such Congresses depends on the care with which the program is prepared. The readers of these Proceedings will have the opportunity to convince themselves that the Austrian Organizing Committee, under the chairmanship of Prof. Peter Berner,

Secretary General of the WPA at the time of the Congress, has attained this goal, and that the scientific quality of the papers presented and now printed is worthy of the tradition of our World Congresses of Psychiatry.

Pierre Pichot

President, WPA
at the time of the VII
World Congress of Psychiatry
President, Scientific Committee

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THE CONTRIBUTION OF SOCIOLOGY TO PSYCHIATRIC RESEARCH

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INTRODUCTION

It is a personal honour to me being invited by the organizers of the Congress to present a paper, but I should not leave unmentioned that the topic, I was persuaded to deal with in 20 minutes, caused me some headache. In order to get along with, I picked up only a few ideas of interest in a psychiatrist's view out of a large realm of thinking called sociology, and set them into a historical perspective.

MAIN OBJECTIVES OF PSYCHIATRIC RESEARCH

The conditions of mental health care and the objectives of psychiatric research determined by them, have been changing since the turn of this century. Under the title of "Social dimensions of mental health", in 1981 the World Health Organization pointed to the strongly increasing amount of chronic ill health and mental health problems all over the world. Long-term disease in general and mental disorder in particular threaten the social functioning of individuals and also burden the network of social relations. Society itself, which should support the individual, often has to bear a great load: Extreme population density or rapid sociotechnical changes endanger for instance the basic sociocultural structures. "The social and behavioural sciences have an important contribution to make to the understanding of illness and the care of patients", as the sociologist E. Mishler expressed it in 1981.

According to Sam Guze's (1977) editorial on the future of psychiatry in relation to the social sciences, research in mental disorders is multimethodical by nature; it must apply those biological, psychological or sociological methods giving adequate access to its subject. Such a fruitful collaboration of sociologists and psychiatrists - and of course also of behaviourists - does exist in fact, for instance in the field of psychiatric epidemiology. However, there are also many wearing theatres of war which burdened the relationship of the two disciplines to each other.

Sciences are also determined by their tradition of thinking. Psychiatry prefers paradigms which are guided by the biological model of morbidity and by psychological theories of personality. It starts from the individual as a research unit.

Sociological approaches start from aggregates of individuals constituting a social system, as Inkeles (1959) defined. Thereby, a range of phenomena, no less complex, comes in, such as the characteristics of social roles, structures, and institutions. The combination of both ways of approach to explain the influences of social processes on the individual morbidity risk has remained a question that is difficult to solve, as was shown by Lee Robins (1978).

THE INFLUENCE OF MACROSOCIAL THEORIES ON PSYCHIATRIC RESEARCH

The study on suicide by the French sociologist Émile Durkheim published in 1987, is the historically most important contribution of empirical sociology to psychiatric research (Cooper and Morgan, 1973). Durkheim verified his hypothesis of a relation between frequency of suicide and social anomia on three levels. He explained his confirming results by the fact that the integration of an individual in society, in church institutions, and in the family conveys the acceptance of norms which regulate the individual behaviour and are clearly directed against suicide. Unfortunately, the latter aspect, the immediate effect of a certain social norm on individual behaviour, can hardly be applied to mental illness.

The essential aspects of Durkheim's theory of anomia - the blurring of norms, social structures, and relations - found a broad reception and became the basis of advanced theories of social alienation, social disintegration or isolation.

Durkheim's second brilliant hypothesis for explanation, the function of family support - in his own words: "There is some kind of moral support that lets the individual take part in collective forces instead of throwing him back at himself, and thereby strengthens him, when he feels to be at the end of his tether" (Durkheim, 1897) - is having a real renaissance in present psychiatric research.

REGIONAL CHARACTERISTICS AS INDICATORS OF SOCIAL AND PSYCHIATRIC PATHOLOGY

With a study on the sociospatial distribution of mental disorders published in 1939, Faris and Dunham introduced the method of social ecology coming from the Chicago school of community sociology. They found the highest rates of first admissions for schizophrenia and for senile psychoses in the socially disorganized centre of the city, where also social pathology concentrated with high rates of criminality and suicide.

Only part of their findings was verified. The social topography of a community is determined by sociospatial migration proceeding more or less rapidly, which, as a consequence, also changes the distribution patterns of health problems.

However, the socioecological approach is still of interest for identifying mental health problems and high risk areas in communities and for planning and evaluating services.

At first, Faris and Dunham gave a causal explanation for the relation between social disorganization and the risk for schizophrenia: The loss of social relationship would lead to seclusion, and in socially isolated persons the loss of social control would produce inadequate behaviour, delusions and hallucinations (see Faris and Dunham, 1939).

The criticism they were exposed to turned out to be fruitful for psychiatric research in two different respects:

(1) Robinson (1950) first pointed to the "ecological fallacy". It says that from morbidity rates in larger units one cannot deduce similar rates in smaller units or identical correlations on the level of individuals.

SOCIAL SELECTION VERSUS SOCIAL CAUSATION

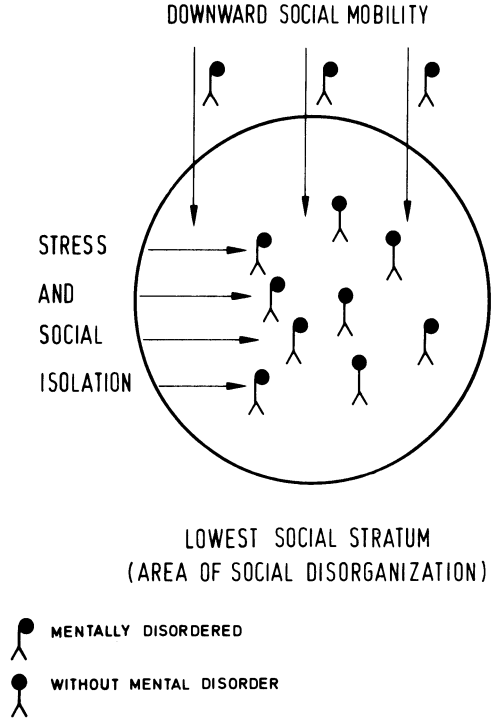

Fig. 1

This was the reason for developing the multilevel analysis (Hummell, 1972; Welz, 1975), which for instance was applied by Dalgard (1980) in the study on individual- and area-related social variables associated with the risk for mental illness in Oslo. It was also applied in the study on the risk for committing suicidal attempts carried out by Welz (1979) in Mannheim.

(2) The second objection, first raised by Myerson (1940), sets the alternative hypothesis of social selection against the hypothesis of social causation. Dunham (1965) tested both models of explanation in a second, carefully designed study in Detroit, in which he controlled the social mobility before the onset of the disease. Part of the elevated risk for schizophrenia in underpriviledged areas and occupations was to be explained by social selection. Among others, Ødegard (1972) confirmed Dunham's findings by longitudinal data of the Norwegian register of psychoses.

THE ASSESSMENT OF RELEVANT VARIABLES

(1) The Dependent Variable: mental health problems and psychopathology

In 1957, Leighton called the insufficiencies in the definition and assessment of the dependent variable "psychopathology" to be the major problem of social-psychiatric research. I have to confine myself to say that since then, the definition of cases, the systems of classification, and the instruments for measuring mental health dimensions have been considerably improved in many areas.

(2) The Dependent Variable: social adjustment or disability

The classification of social behaviour in mental disorders - e.g. laid down in the International Classification of Impairment, Disabilities and Handicaps (WHO, 1980) - and its assessment have also been making considerable progress, as Myrna Weissman (1975) showed in a survey on 15 scales for assessing social adjustment. A prerequisite for these advances was the concept of the social role originating from the American sociologist G.H. Mead (1934). This concept allows the assessment of an individual's social performance with respect to the expectations and norms of his referent group (Weissman, 1975; Cooper, 1980). Irrespective of some questions still unsolved - such as the problem of norms in role performance - sociology made an essential contribution to the inquiry into the social dimensions of course and outcome of psychiatric disorders by introducing the concept of social roles.

(3) The Independent Variable: socioeconomic class and social status

The classification of a population in social classes or status groups basing on different theoretical traditions brought to psychiatry the advantage of a quantifiable "independent" variable. The main dimensions that are mostly used for setting up a multiple index, are family income, education, and occupational status. Since the first epidemiological studies, carried out jointly by psychiatrists and sociologists - e.g. by Hollingshead and Redlich (1958), Srole et al. (1962), Leighton et al. (1963) -,had found an association between low social

status and poor mental health, their findings have mostly been verified by a very large number of investigations made in numerous countries (see Gruenberg and Leighton, 1965; B. and B. Dohrenwend, 1969, 1980). However, mental illness is only one aspect of a more extensive misery. Low social status also involves poor physical health, high mortality, insufficient helpseeking behaviour, and various risk factors.

For explaining why mental disorders are not equally distributed over classes, quite a few interesting sociological models were applied, e.g. the model of the effects of class-specific sub-cultures on different processes of socialization (Parsons, 1951; Merton, 1938; Kohn, 1972) or the concept of varying strain and coping mechanisms according to social class (Srole et al., 1962; B. and B. Dohrenwend, 1974). The inconsistency of the results does not allow to draw far-reaching conclusions at present. Those variables explaining the largest proportion of the variance in poor mental health occurring in the lowest status group, are factors of low complexity, such as low family income and low level of education.

Finally, we should not forget that social status has become an important background variable, the control of which reduces the sources of errors made when assessing the influence of other criterion variables, such as the influence of biological or psychological parameters on psychopathological indices.

LIFE EVENTS AND SOCIAL SUPPORT

Let me return to the critical question of social factors possibly influencing the individual morbidity risk: With the analysis of social networks first applied by the sociologist Elizabeth Bott in London (1957), we seem to have made a step forward towards the explanation of some microsocial processes contributing to the inception or chronification of various psychiatric disorders. As Susser (1981) recently stated, the social network analysis made it possible to reintroduce a classical model of disease inception into the so-called life-event research: the triad agent, environment, host.

This model implies for instance (1) life events as 'agents', (2) internal coping resources as immunity or vulnerability factors, and (3) external resources of the social network as situational factors, which cushion or exacerbate the impact of stressful events (Brown et al., 1972).

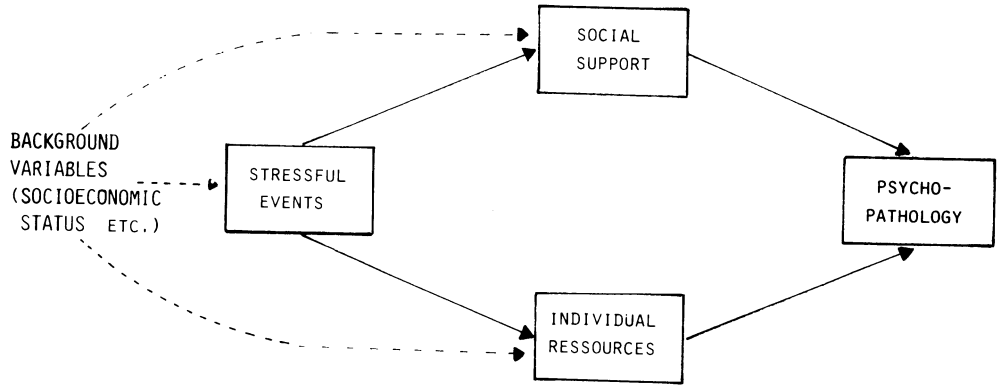

Fig. 2 A Model of Relationship between Social Environment and Psychiatric Disorder

The model has been used for testing the influence stressful events and insufficiencies of social support have on the risk for neurotic disorders (Henderson, 1978), depressive states (Brown and Harris, 1978) and on social adaptation in the course of chronic depression and other diseases (Surtees, 1980; Surtees and Ingham, 1980; Lin et al., 1979; Mueller, 1980).

Social networks can provide for instance emotional warmth, attachment, esteem, and cognitive support, or fail to do so. It is often neglected that they may also convey negative influences, like dependency or patterns of destructive behaviour. Two examples for this may be the spread of heroin abusing (De Alarcon, 1969; Welz and Niedermeier, 1980; Häfner et al., 1983) by social networks.

The investigation of supportive and of destructive factors in connexion with psychosocial strain and coping resources enriched the classical psychiatric theory of the inception of reactive disorders. Jointly with vulnerability, biological reaction patterns, and stressful events, they may have an effect on the onset and course of diseases.

In view to the main problems psychiatric research is confronted with - i.e. chronic diseases and mental health problems - such 'practical' paradigms, which

sometimes even seem trivial, but at the same time provide an approach to intervention and to smaller steps towards explanation, are still more fruitful for psychiatric research than sociological theories of long range.

CONCLUSION

As I mentioned in the beginning, I have tried to cope with an unsolvable problem: the description of the influence of sociology, a rather extensive and partially chaotic discipline, on a not very dissimilar science in 20 minutes time. Thus, I had to confine myself to rather selective and general views. I hope to have shown at least that in large oases of high-standard research this influence proved to be fruitful and free from anti-psychiatric ideologies.

REFERENCES

Alarcon, R. de, 1969, The spread of heroin in a community. Bulletin on Narcotics, 21:17.

Badura, B. (ed.), 1981, "Soziale Unterstützung und chronische Krankheit. Zum Stand sozial-epidemiologischer Forschung", Suhrkamp, Frankfurt/M.

Bott, E., 1957, "Family and social network. Roles, norms and external relationships in ordinary urban families", Tavistock, London.

Brown, G.W., Birley, J.L.T., and Wing, J.K., 1972, Influence of family life on the course of schizophrenic disorders: a replication. British Journal of Psychiatry, 121:241.

Brown, G.W., and Harris, T., 1978, "Social origins of depression", Tavistock, London.

Cooper, B., and Morgan, H.G., 1973, "Epidemiological psychiatry", Charles C. Thomas, Springfield, Illinois.

Cooper, J.E., 1980, The description and classification of social disability by means of a taxonomic hierarchy, in: "Epidemiological research as a basis for the organization of extramural psychiatry", E. Strömgren, A. Dupont, and J.A. Nielsen (eds.), Munksgaard, Copenhagen.

Dalgard, O.S., 1980, Mental health, neighbourhood, and related social variables in Oslo. Acta Psychiatrica Scandinavica, Suppl. 285:298.

Dohrenwend, B.P., and Dohrenwend, B.S., 1969, "Social status and psychological disorder: a causal inquiry", John Wiley and Sons, New York.

Dohrenwend, B.P., and Dohrenwend, B.S., 1974, Overview and prospects for research on stressful life events, in: "Stressful life events. Their nature and effects", B.S. Dohrenwend, and B.P. Dohrenwend, eds., John Wiley and Sons, New York.

Dohrenwend, B.P., 1980, Soziokulturelle und sozialpsychologische Faktoren in der Entstehung psychischer Störungen, in: "Sozialer Stress und psychische Erkrankung", H. Katschnig, ed., Urban und Schwarzenberg, München, Wien, Baltimore.

Dunham, H.W., 1965, "Community and schizophrenia: an epidemiological analysis", Wayne State University Press, Detroit.

Durkheim, E., 1897, "Le suicide", 1st ed., Paris; 3rd ed., Presses universitaires de France, Paris (1960).

Durkheim, E., 1951, "Suicide", The Free Press of Glencoe, Ill.

Faris, R.E.L., and Dunham, H.W., 1939, "Mental Disorders in urban areas: an ecological study of schizophrenia and other psychoses", University of Chicago Press, Chicago.

Gruenberg, E.M., and Leighton, A.H., 1965, Epidemiology and psychiatric training, in: "Concepts of community psychiatry: a framework for training", E.E. Goldston, ed., Public Health Service Publication No. 1319, Washington D.C.

Guze, S.B.,1977,The future of psychiatry: medicine or social science? An editorial, Journal of Nervous and Mental Disease, 165:225.

Häfner, H., Welz, R., Gorenc, K., and Kleff, F., 1983, Selbstmordversuche und depressive Störungen, Schweizer Archiv für Neurologie, Neurochirurgie und Psychiatrie, submitted for publication.

Henderson, S., 1978, A development in social psychiatry: the systematic study of social bonds, Journal of Nervous and Mental Diseases, 168:63.

Hollingshead, A., and Redlich, F.C., 1958, "Social class and mental illness", John Wiley and Sons, New York.

Hummell, H.J., 1972, "Probleme der Mehrebenenanalyse", 1. Aufl., Teubner, Stuttgart.

Inkeles, A., 1959, Sociology and psychology, in: "Psychology: a study of a science", S. Koch, ed., vol. 6, McGraw-Hill, New York.
Kohn, M.L., 1972, Class, family, and schizophrenia. A reformulation, Social Forces, 50:295.
Kreitman, N., 1980, Die Epidemiologie von Suizid und Parasuizid, Nervenarzt, 51:131.
Leighton, A.H., Clausen, J.A., and Wilson, R.N.,1957, Introduction: some key issues in social psychiatry, in: "Explorations in social psychiatry", A.H. Leighton, J.A. Clausen, and R.N. Wilson, eds., Basic Books, New York.
Leighton, A.H., Clausen, J.A., and Wilson, R.N., 1957, Orientation, in: "Explorations in social psychiatry", A.H. Leighton, J.A. Clausen, and R.N. Wilson, eds., Basic Books, New York.
Leighton, D.C., Harding, J.S., Macklin, D.B., MacMillan, A.M., and Leighton, A.H., 1963, "The character of danger. Psychiatric symptoms in selected communities. The Stirling County study of psychiatric disorder and socio-cultural environment", vol. III, Basic Books, New York.
Lin, N., Ensel, W.M., Simeone, R.S., and Kuo, W., 1979, Social support, stressful life events, and illness: a model and an empirical test, Journal of Health and Social Behaviour, 20:108.
Mead, G.H., 1934, "Mind, self, and society", ed. by Morris, C.W., The University of Chicago Press, Chicago.
Merton, R.K., 1938, "Social theory and social structure", Free Press, Glencoe/Ill.; 3rd ed. New York, London (1968).
Mishler, E.G., 1981, Viewpoint: critical perspectives on the biomedical model, in: "Social contexts of health, illness, and patient care", Mishler, E.G., Amara Singham, L.R., Hauser, S.T., Liem, S.D.R., Osherson, S.D., and Waxler, N.E., eds., Cambridge University Press, Cambridge, London, New York, New Rochelle, Melbourne, Sydney.
Mueller, D., 1980, Social networks: a promising direction for research on the relationship of the social environment to psychiatric disorder, SSM 14A:147.
Myerson, A., 1940, A book review: Faris and Dunham: Mental disorders in urban areas, American Journal of Psychiatry, 96:995.

Ødegard, Ø., 1972, Epidemiology of the psychoses, in:"Psychiatrie der Gegenwart", 2. Aufl., Bd. II/1,"Klinische Psychiatrie I", Kisker, K.P., Meyer, J.-E., Müller, C., und Strömgren, E. (Hrsg.), Springer: Berlin, Heidelberg, New York.

Parsons, T., 1951, "The social system", Free Press, Glencoe, Ill.

Robins, L.N., 1978, Psychiatric epidemiology, Arch. Gen. Psychiatry, 35:697.

Robinson, W.S., 1950, Ecological correlations and behaviour of individuals, American Sociological Review, 15:352.

Srole, L., Langner, T.S., Michael, S.T., Opler, M.K., and Rennie, T.A.C., 1962, "Mental health in the metropolis: the Midtown Manhattan Study", McGraw Hill, New York.

Surtees, P.G., 1980, Social support, residual adversity and depressive outcome, Social Psychiatry, 15:71.

Surtees, P.G., and Ingham, J.G., 1980, Life stress and social outcome: application of a dissipation model to life events, Social Psychiatry, 15:21.

Susser, M., 1981, The epidemiology of life stress, Psychological Medicine, 11:1.

Weissman, M.M., 1975, The assessment of social adjustment. A review of techniques, Arch. Gen. Psychiatry, 32:357.

Welz, R., 1975, Probleme der Verwendung von Kollektiv- und Individualdaten im Rahmen der psychiatrisch-epidemiologischen Forschung, Social Psychiatry, 10:189.

Welz, R., 1979, "Selbstmordversuche in städtischen Lebensumwelten. Eine epidemiologische, ökologische und mehrebenenanalytische Untersuchung über Häufigkeit und regionale Verteilung von Selbstmordversuchen in Mannheim", Beltz-Verlag, Weinheim.

Welz, R., und Niedermeier, C., 1983, Diffusionstheorie der Ausbreitung des Drogenkonsums, in: "Drogenabhängigkeit - Ursachen und Verlaufsformen - ein Handbuch", Lettieri, E.J. und Welz, R. (Hrsg.), Beltz Verlag, Weinheim (in press).

World Health Organization, 1980, "International classification of impairments, disabilities, and handicaps. A manual of classification relating to the consequences of disease", WHO, Geneva.

World Health Organization, 1981, "Social dimensions of mental health", WHO, Geneva.

FAMILIAL FACTORS IN DEPRESSIVE DISORDERS: CHILDREN AT RISK

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The topics of the two plenary sessions for today are concerned with the sociological and with the genetic aspects of psychiatry. The study of familial factors as risk for a psychiatric disorder could be presented in either session. Family studies are useful precisely for their ability to bridge both genetic and environmental risk factors in disease.

While the dichotomy between genes and environment may seem simple (genes are transmitted in the chromosomes received from one's parents and the environment consists of the things to which one is exposed after conception) with an increasingly greater understanding of diseases this dichotomy has become less clear.[1] No disease is determined solely by genes or by environment, nor by any one single cause. Rather than ask whether a disease is caused by genes or environment, one should determine the limits and characteristics of the factors that produce each kind of disease.

In studies of families the observation that certain disorders cluster in families raises the question as to what extent the familial recurrence is due to the repetition of specific gene combinations in families, and to what extent it is due to shared environmental factors. Twin and cross-fostering studies provide the most powerful methods for detecting genetic etiology. Family studies, while less conclusive, can provide a considerable amount of information about a variety of risk factors contributing to the development of a disorder. A study of children is particularly useful as early signs of the disorder, and the factors contributing to their onset, may be detected.

Our interest in the children of depressed parents began over ten years ago when we observed that acutely-ill depressed women, compared with normal nonpsychiatrically-ill women in their neighborhood, were more irritable and resentful of their children, as well as less affectionate and involved with them.[2] Moreover, the children continued to manifest many problems long after their mother's recovery. Because these earlier studies focused on the social and interpersonal relationships of depressed women, the children's problems were not systematically assessed. These studies, however, led to our current interest in genetic-family studies of children of depressed parents. This paper summarizes our preliminary data comparing the offspring (ages 6-18) of probands with major depression to the offspring of normal controls. It differs from many previous studies in that: 1) a matched control proband group is included for comparison purposes; 2) DSM-III diagnoses are made on children; 3) a large sample of children is included; and 4) best estimate diagnoses in children are made blindly with respect to the clinical status of the proband. However, this is a pilot study in that the data are based on parents' reports of their children rather than direct assessment of the children.

We now have under way a large-scale study incorporating direct interviews of these children.

METHOD

The subjects studied were the children, ages 6-18, of probands from a family-genetic study of affective disorders in adults. The probands of the children studied were adults (18 years and older) and derive from one of the following groups: severe major depressives (with severity defined as hospitalization) (N=44); mild major depressives (i.e., ambulatory, never hospitalized) (N=89); or a normal never-psychiatrically-ill control group (N=82) drawn from a community sample in New Haven, Connecticut. In this report the results from the severe and mildly ill depressed probands are combined in order to increase the sample size of children. Thus, there were 215 probands. Of the 215, 100 probands had 194 children between the ages of 6-18 years.

The proband groups were white and group matched by age and sex. All of the depressed probands were primary non-bipolar depressives. The diagnostic assessment of the probands was based on RDC criteria following a modified SADS-L interview. The full details of that study, including design, diagnostic procedures, and findings, have been described elsewhere.[3-7]

SUMMARY

The findings showed:

1. Children of depressives are at increased risk for psychological symptoms, treatment for emotional problems, school problems, suicidal behavior, and DSM-III diagnoses. The magnitude of the risk is increased threefold for any DSM-III diagnosis in the children of depressed probands compared with the children of normal probands.

2. Major Depression is the most common psychiatric disorder in children of depressives, followed by attention deficit and separation anxiety. Multiple diagnoses are common.

3. The risk to children of major depression and of any DSM-III diagnosis increased linearly if both parents were psychiatrically ill than if only one or neither parent had psychiatric illness.

4. The proband's current age, sex, social class, number of children, childhood history of behavioral problems such as stuttering, enuresis, sleepwalking, or separation from their own parents did not increase the risk of major depression or any DSM-III diagnosis in his/her children.

5. The significant predictors of risk to children were early onset of the proband's depression, an increased number of the proband's first degree relatives who were ill with any psychiatric disorder and/or major depression, and if the proband was divorced, separated or widowed.

These findings are provocative and, in future reports, will be explored more fully according to severity and subtype of parental depression, and by timing the onset of disorders in children. The implications of these findings for understanding gene-environment interactions will be examined on the basis of the data reported here, and the most comprehensive data we are now collecting through the direct interviewing of these children and through the study of their first-degree relatives.

This study is presented to illustrate an approach to integrating sociological and genetic factors in the study of psychiatric disorders. It is our conviction that an integrated approach will be the most informative and that systematic studies of biological families will be fruitful.

ACKNOWLEDGEMENTS

This research was supported in part by Alcohol, Drug Abuse, and Mental Health Administration grant MH28274, from the Center for Epidemiologic Studies, and from the Center for Studies of Affective Disorders, National Institute of Mental Health, Rockville, Maryland.

REFERENCES

1. B. MacMahon and T.E. Pugh, "Epidemiology: Principles and Methods" Little Brown, Boston, Massachusetts (1970).
2. M.M. Weissman and E.S. Paykel, "The Depressed Woman: A Study of Social Relationships", University of Chicago Press, Chicago, Illinois (1974).
3. M.M. Weissman, E.S. Gershon, K.K. Kidd, B.A. Prusoff, J.F. Leckman, E. Dibble, J. Hamovit, W.D. Thompson, D.L. Pauls, and J.J. Guroff, Psychiatric disorders in the relatives of probands with affective disorders: The Yale-NIMH collaborative family study, Arch Gen Psychiatry (In press).
4. M.M. Weissman, K.K. Kidd, and B.A. Prusoff, Variability in rates of affective disorders in relatives of depressed and normal probands, Arch Gen Psychiatry. 39:1397-1403 (1982).
5. M.M. Weissman, B.A. Prusoff, G.D. Gammon, K.R. Merikangas, J.F. Leckman, and K.K. Kidd, Psychopathology in the children (ages 6-18) of depressed and normal parents, J Amer Acad Child Psychiatry (In press).
6. J.F. Leckman, D. Sholomskas, W.D. Thompson, A. Belanger, and M.M. Weissman, Best estimate of lifetime psychiatric diagnosis: A methodological study, Arch Gen Psychiatry. 39:879-883 (1982).
7. J.F. Leckman, M.M. Weissman, K.R. Merikangas, D.L. Pauls, and B.A. Prusoff, Panic disorder increases risk of major depression, alcoholism, panic, and phobic disorders in affectively ill families, Arch Gen Psychiatry (In press).

THE CONTRIBUTIONS OF SOCIOLOGY TO THE UNDERSTANDING OF MENTAL DISORDER

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Social forces affect almost every aspect of mental illness ranging from its occurrence and expression, and how it is interpreted, to control and remedial efforts. Thus it is difficult to conceive of a mental illness process outside the contours of a particular culture and society. Genetic and other biological precursors interact with sociocultural influences affecting the prevalence and course of disorder and the degree of misery and disruption it causes.

Sociologists focus on how personality is developed and affected through processes of interaction and association in families, peer groups and communities. Within the context of a social conception, mental illness is in part a consequence of strain in social roles, failures in appropriate learning, or rapid social and cultural changes that overwhelm individual adaptation. These social factors interact with genetic and other biological propensities and generate varying rates and intensities of disorder.

The study of social factors is required to understand the determinants of disorder, alternate modes of expression of equivalent biological propensities, or the substitutibility of response. How are we to equate findings of greater prevalence of depression among women and greater prevalence of alcoholism and personality disorder among men? Are these independent processes or alternative manifestations of comparable inner distress? Why is it that Chinese populations are found to have high rates of neurasthenia, accompanied by vegetative physical symptoms associated with depression, but low rates of affective symptoms? Culture obviously influences the expression of inner states, but

the range and limits of such constraints remain unknown. Existing evidence indicates that sociocultural factors profoundly affect the course of schizophrenia and other disorders; and that in some cultures rates of remission of schizophrenics is surprisingly high following the first episode.

But society and culture affect more than the expression of inner states. There is overwhelming evidence that biological events, including heart rate, blood flow, skin temperature and most mental processes can be conditioned, and society and culture are powerful conditioning influences. While mental illness in one form or another is recognized in all cultures, and certain syndromes may be universal, their incidence may still be dependent on social forces. The evidence, while unpersuasive in respect to psychotic disorders, is overwhelming in the wide range of non-psychotic disorders of interest to psychiatry.

The Role of Social Cohesion

In his classic study of suicide, sociologist Emile Durkheim (1951) empirically explored the social correlates of suicide and theorized about the influence of collective processes on the individual's tendency toward self-destruction. The links between lack of social integration and a wide variety of social, psychiatric, and physical health indicators have been repeatedly documented (Merton and Nisbet, 1961). Although such findings are not always consistent, many of the discrepancies are attributable to varying concepts and definitions of integration and the different dependent measures used. The concept of integration embraces such diverse indicators as intimacy, participation in family and friendship networks, activity in voluntary groups, and acquaintanceship. Also, community integration can persist under conditions of considerable societal disruption that complicates description. Persons are often extraordinarily creative in developing informal social networks that assist them and help sustain them in dealing with adversities. Such supportive systems have been found in combat groups, prisons, concentration camps, and even mental hospitals (Mechanic, 1974). People often establish their own islands of stability in the midst of great instability.

Although there is a long history in social science research of examining social integration at the societal level in relation to varying dependent variables, it is only more recently that attention of researchers has turned to measuring social integration or social support as protective factors that insulate individuals in stressful situations from social and psychological breakdown. It is increasingly recognized that social ties, intimate relations, and routine patterns of activity play an essential part in processes of coping and adaptation. A major difficulty is the varying definitions of support, integration, and cohesion, and the

lack of clear specification of the way they protect persons against assaults.

Social supports contribute to social and psychological functioning in a variety of ways. At a broad level, social networks are sources of resources, information, assistance, and encouragement. When support is sufficient, it may contribute importantly to self-esteem and may even provide the central meaning in a person's life. Ties within social networks are complex, however, and may be sources of anxiety and unfavorable social comparison as well as providing opportunities for reassurance and tangible assistance (Mechanic, 1978d). Moreover, social ties often bring expectations, demands, and obligations that may be further sources of strain. Thus crude aggregate measures of memberships in social groups and community activities often fail to capture those aspects of community associations essential for understanding psychological functioning.

At the core of the concept is the idea of an intimate attachment, and Brown and Harris (1978) have found that such intimacy protects against depression while more conventional alignments do not. Intimacy is an essential mode of self-validation and often provides a basis for meaning and commitment. Less intimate attachments may provide assistance, information, encouragement, and other forms of nurturing, but may not be crucial to self-validation and self-esteem and thus may be less protective in situations of severe loss. Social integration, in contrast, as measured by involvement in voluntary organizations, community activities, neighborhood groups, and the like is more likely to reflect the individual's tie to established routine, rewarding associations, and a sense of stability. Such a concept is quite different from intimacy and may influence other aspects of functioning. It has been suggested that close community ties demand greater conformity, thus constituting a source of anxiety (Brown and Harris, 1978). We know too little about the way varying types of support function, but such measures are increasingly used in social psychiatry studies, and we are likely to clarify these concepts better in the future (Kaplan, Cassel, and Gore, 1977).

Social Stratification and Psychiatric Disorder

There is no concept more important to social science than the concept of social class. Such concepts may be used as a component of an overall theoretical interpretation as in Marxist social analysis or as a descriptive summary of the various cultures of individuals associated with education, occupation, income, and residence. Because most of the work relevant to psychiatry has been in this latter vein, the discussion focuses on social class as a descriptive concept.

While most epidemiological work in psychiatry treats social class as a descriptive variable, sociologists seek to understand what it is about varying social strata that account for the many differences found. Thus they focus on the way attitudes and values, modes of socialization, and patterns of typical associations may account for observed differences in achievement, interests, behavior, pathology and death. How, they ask, do different social class environments affect self-esteem, coping flexibility, ideologies, political responses, and values and aspirations (Kohn, 1977)?

Although it had long been recognized that social class was linked to the prevalence of mental illness and to responses to the mentally ill, it was not until the late 1950s with the publication of the Hollingshead and Redlich (1958) study in New Haven that social class became a variable of major interest to psychiatrists. For several decades the epidemiological literature had documented a close link between social stratification and mental illness, particularly an association between social class and schizophrenia (Dohrenwend and Dohrenwend, 1969). The repeated observation of a disproportionate number of schizophrenics in the lowest social strata, noted in studies undertaken throughout the world, stimulated a continuing controversy concerning the interpretation of the association. The matter still remains unsettled, but more recent evidence argues that the disproportionate occurrence of schizophrenia in the lowest social strata is a consequence of genetic selection and either downward social mobility or failure to more upward with one's age cohort as a result of the debilitating consequences of the disorder (Turner and Wagenfeld, 1967; Mechanic, 1978a, pp.214-221). All of the studies, however, are sufficiently ambiguous to allow an alternative causation hypothesis to explain at least part of the observed variation.

Kohn (1972), for example, has maintained that selection cannot account for the total effects attributable to social class. He suggests that schizophrenia is an outcome of a genetic vulnerability interacting with environmental stress and impaired ability to deal with it because of class-linked conformity orientations. He infers the existence of these orientations from values such as obedience, good manners, and cleanliness, and suggests that underlying these is a rigidly conservative view of man, fearfulness, distrust, and fatalism. Such orientations that make it difficult to adapt resourcefully, he believes, are linked with lower-class position and account for at least part of the frequently observed relationship between schizophrenia and social class.

The importance of intervening variables is emphasized by recent studies of prognosis of schizophrenia, showing rates of remission of schizophrenia following an initial episode to vary

considerably and to be maintained over long periods of time (World Health Organization, 1979; Murphy and Raman, 1971; Waxler, 1979; Clausen, Pfeffer and Huffine, 1982). In the World Health Organization study, at two-year follow-up, 27 percent of schizophrenics had a complete recovery, with the proportions varying from 6 percent in Denmark to 58 percent in Nigeria. While patients in each country are not representative of the total population of schizophrenics in that nation, the findings, consistent with those of other studies, imply that we should be examining very carefully the impact of social expectations, family life, and interpersonal relationships on the course of schizophrenia.

Social class has also been associated with such varied responses as definitions of psychological disorder, reactions to the mentally ill, pathways into care, types of care received, length of treatment, and retention and withdrawal from treatment. In brief, most studies find that the most favored and prestigious care is given to the affluent and educated. Although these findings are in large part attributable to economic capacity to purchase varying types of care, social class patterns have been noted even in circumstances in which there are no economic barriers (Myers and Schaffer, 1954). Studies in the United States indicate that in the last two decades the gap between the affluent and the poor in the use of psychiatric services has very much diminished, and that such services are more acceptable to a wide spectrum of the population (Kulka, Veroff, and Douvan, 1979).

Social class has also been associated with depression, psychological distress syndromes, antisocial behavior, drug addiction, and other social pathologies (Robins, 1979). Increasingly, investigators are focusing less on the simple association and searching more carefully to identify the dimensions of life in varying social strata that account for differences in the prevalence of pathology. Brown and Harris (1978), for example, suggest that the high prevalence of depression in lower-class women is less a result of differential life events and more a product of greater vulnerability to such events because of life circumstances. Because most persons in the lowest social strata do not develop pathologies, class itself cannot serve as an adequate explanation of outcomes. However, class differences suggest various areas of difference worthy of etiologic exploration.

Sex and Psychiatric Disorder

Numerous studies report a higher prevalence of depression, neurosis, and psychophysiological and distress syndromes in women as compared with men (Weissman and Klerman, 1977; Mechanic, 1980). In contrast, men more commonly engage in antisocial behavior, aggressive risk-taking, alcoholism, and drug abuse (Robins, 1966).

There appears to be no consistent or large differences among men and women in the prevalence of schizophrenia (Dohrenwend and Dohrenwend, 1969). This epidemiological literature has contains a great deal of sociological speculation and some research, but the underlying theoretical issues are difficult to resolve.

As with many other questions in psychiatry, the ambiguity of definition and uncertain boundaries of psychiatric disorder pose difficulties. One view is that the higher prevalence of depression and related problems among women reflects a real excess of mental illness in women. A contrasting view is that men and women express distress in various ways and that sociocultural influences lead men to express their problems more through antisocial activities while women complain more of intrapsychic and psychophysiological distress. From the latter perspective, the differences among men and women are much less significant if these various modes of expressing distress are taken into account. Newmann (1982) has illustrated in one large sample that differences in rates of depressive symptoms among men and women primarily occurs on less serious symptoms as judged by psychiatrists. It is not clear how this issue of definition can be resolved fully, and at this point it appears most productive to focus on differences in respect to individual diagnostic categories as compared with global definitions of psychiatric disorder.

Some investigators, however, attempt to account for the alleged higher prevalence of psychiatric disorder among women in general (Gove and Tudor, 1973; Gove, 1978). The basic argument is that the differences reflect the strains in the social role of women in contemporary society, the stresses and frustrated expectations of the housewife role, and the discrepancies between education and preparation of women for adult roles and the realities of their daily lives. Although all of these issues may relate to the experience of distress, these constitute only a small sample of stressors for either women or men, and the literature on sex and psychiatric disorder concentrates almost exclusively on the strains associated with women's roles.

The fact is, however, that in modern society women report more depression and anxiety than men. A variety of conceptions have been suggested to explain the female excess including biological differences, a greater sense of helplessness because of the position of women in society, learned cultural differences in recognizing and expressing distress, differences in accepting dependency associated with seeking help, and the like (Mechanic, 1978c). It has been suggested that marriage is much more protective for men than for women, and some studies indicate that single women fare better than single men.

Other studies show that jobs may protect married women from depression. In a recent study we found a small protective effect, except when the working woman had minor children in the household. This was particularly true for women in families of lower income, and we believe that in lower income families the strain of working and raising children increases distress among married women.

Illness Behavior, Help-Seeking, and the Societal Reaction

Social factors not only affect the occurrence and course of psychiatric conditions, but also form the processes of identification, definition, and response to problems and symptoms. Indeed, the concepts of psychiatric disorder and illness behavior blend into one another, and often it is difficult to distinguish them. Many patients with diffuse complaints of psychological distress often seen at psychiatric outpatient departments, by primary care physicians, and by a wide range of other helping professionals do not have an identifiable clinical psychiatric disorder (Mechanic, 1978a, pp. 249-289). Some subgroup of patients can be viewed as having an exaggerated focus on self and sense of demoralization that reflect their illness behavior patterns as they have been shaped by developmental experiences (Mechanic, 1979).

Patients with psychological distress and psychiatric illness and their loved ones have greatly varying propensities to recognize these problems, to accept the need for care, and to seek assistance from alternative professionals and social agencies. These responses are linked to social and cultural factors and are modified over time depending on changes in knowledge and potential for intervention, reduction in social stigma, increased education and sophistication, and changing social values.

Studies of self-definition of psychological disorder indicate that persons with symptoms are more likely to view themselves as having a psychiatric problem and to seek psychiatric care when they are involved in a social circle with others who are in psychological treatment (Kadushin, 1969). Such social circles are characterized by particular values, life orientations, and other cultural predispositions; and those who seek outpatient care are more likely to have knowledge about such care resources and know others who have used such facilities. Help seeking involves a fairly elaborate selection process in which the patients often seek out forms of treatment or practitioners compatible with their particular perceptions, values, knowledge, and cultural inclinations (Kadushin, 1962).

Not all patients with psychiatric problems recognize the difficulty or desire help. However, their behavior may become sufficiently visible, disruptive, threatening, or annoying to result in others taking action. The response of family, neighbors,

or community officials reflects not only the behavior being defined but also their own expectations, knowledge, understanding and tolerance, and their own needs. The processes through which social labeling of the mentally ill occurs and the influences on the societal reaction have received continuing study focusing on such issues as class differences in response and pathways into care (Hollingshead and Redlich, 1958), the role of bizarre behavior and instrumental performance on tolerance and demands that the patient be removed from community settings (Freeman and Simmons, 1963; Angrist et al., 1961), and family pressures on admission to and release from mental hospitals (Greenley, 1972). Although relationships between sociodemographic variables and social labeling reflect various intervening variables already noted, such as conceptions of mental illness, tolerance, knowledge, and understanding, there has been a continuing association noted between social class and the societal reaction. More affluent persons come into care through families and physicians, but the poor are more likely to arrive as a result of the intervention of police and other community agencies. Over time and with greater receptivity to psychiatric services, it appears that there is more willingness in all social strata to accept psychiatric care without coercive intervention. Moreover, with emphasis on the civil liberties of the mentally ill and greater tolerance of the mentally impaired in community settings, the public is more reluctant to intervene than in prior years (Stone, 1975,75-176).

Despite greater receptivity to psychiatric care, there continues to be considerable delay in the recognition of psychiatric illness and psychiatric intervention, with patients and their families engaging in considerable efforts to normalize disturbing behavior. Often action is taken only after the family and community can no longer contain the bizarre and disruptive features of the patients' behavior (Clausen and Yarrow, 1955). This may result because the behavior is increasingly difficult to manage or because the needs and wishes of family members change, making it more difficult to contain deviant behavior. Bizarre, threatening, and grossly inappropriate behaviors are more likely to result in public intervention than poor social functioning and impaired instrumental behavior (Freeman and Simmons, 1963; Brown et al., 1966). Instrumental behavior is of greater importance in assessments made by more affluent and better-educated persons with stronger instrumental values.

Just as entry into psychiatric care depends as much on social behavior and social judgments as on clinical states, release to the community is also influenced substantially by family desires and pressures, by the availability of community settings to house and support the patient adequately, and by community attitudes. Rapid deinstitutionalization of chronic mental patients in the United States and elsewhere has been highly dependent on income support

and medical care payment programs that have provided financial assistance allowing the retention of patients in communities (Scull, 1977). Such independent support has made it possible to retain in the community patients who lack potential kinship supports or whose families no longer wish to assume responsibility.

Labeling Theory and the Mentally Ill

One of the major themes in mental health research in the 1960s was the effect of labeling on the occurrence and course of psychiatric impairment. Such theory and the work relevant to it have been a continuing source of vigorous controversy. Much of the difficulty evolved from a lack of specificity among proponents as to whether they were addressing issues of etiology, course, or treatment effects and whether the theory was focused on understanding impairment itself or the manner in which it is defined and how secondary disabilities develop. Proponents of labeling theory often appear confused themselves as to their basic tenets.

Much of the debate on labeling and mental illness has focused on the question of whether psychiatric disorders are illnesses or simply imposed definitions on persons who transgress various social, moral, and legal expectations (Szasz, 1974; Rosenhan, 1973). To the extent that the later conception prevails, then labeling is a major cause of mental illness by definition. Unfortunately, the debate about the use of the medical model in psychiatry has generated more heat than light, and the discussion tends to focus more on abuses of psychiatry in various practice settings than on the scientific validity and practical utility of varying models for diagnosis and treatment (Mechanic, 1978b). There is very little basis in the research literature to support the contention that labeling processes contribute in any fundamental way to the occurrence of psychiatric disorder (Gove, 1970; Robins, 1975).

Although labeling theory has not contributed a great deal to understanding causation, it is a helpful and often powerful perspective for understanding the course of disorder, the magnitude of social disability, modes of utilizing services, and patients' concepts of themselves and their conditions. Patients with comparable physical and psychological disorders display a wide range of adaptive responses. Some become totally incapacitated, dependent, and apathetic, while others maintain acceptable levels of functioning at least in some spheres. Labeling, social expectations, and opportunities for normal functioning or their denial all shape the expression and consequences of disorder. Social definitions affect the patients' self-image, sense of hope and efficacy, and willingness to remain actively involved in work or social activities. Labeling and assumptions associated with

varying labels imply expected levels of functioning and disability, and patients are highly sensitive to such social cues about what their capabilities might be. Labeling theory has again sensitized us to the importance of social definitions as constraints on behavior and the way such definitions can be used in the management of patients to sustain their involvement, bolster their self-esteem, and increase the quality of their lives (Mechanic, 1977).

Attribution Theory

A major area of research in social psychology deals with the way people interpret the causality of events, and such research has great importance for psychiatry (Nisbett and Valins, 1971). Attribution theory is concerned with meaning in social action and the motives and traits attributed to oneself and others under various conditions. Particularly in respect to illness perceptions, an attribution approach examines the way people appraise their inner states and behavior and explain changes in feelings and experience, and the effects of such definitions on subsequent feelings and behavior.

The dramatic shifts in the care of the mentally ill, in assumptions concerning their capability to remain in the community, and in definitions of the need for institutional care, are as much a product of changing attributions as they are of new knowledge. We have learned that to some degree normalization of symptoms and an emphasis on positive aspects of functioning may do a great deal to maintain and enhance social functioning. In the past, assumptions of the helplessness, irresponsibility, and dangerousness of the mentally ill contributed to exacerbating these reactions by isolating patients, stigmatizing them, and excluding them from ordinary social opportunities.

Coping Theory

In the last two decades the focus for study of social adaptation has shifted from ego defense processes to investigation of how persons actively attempt to shape their environments, how they deal with problems and challenges, and how they manage interpersonal relationships. This new emphasis has considerable potentiality for improving approaches to crisis intervention and for developing community care programs for sustaining chronic mental patients in the community (Lazarus, 1966; Coelho, Hamburg, and Adams, 1974).

Adaptation can be viewed as reasonable compatibility between environmental and interpersonal demands and the capacity of individuals to deal with such demands. Dealing with expectations

and challenges involves three tasks. First, the individual must be motivated to meet the challenge, and such motivation is induced by sociocultural incentives and interpersonal pressures. Second, the person must have the necessary skills to manage varying aspects of the challenges confronted. Much of family socialization and formal schooling is directed at providing the problem-solving skills necessary for adult roles. Third, individuals must have means to control anxiety and discomfort not only to moderate pain and suffering, but also to allow effective involvement with the environment to continue. Successful defense may depend on a variety of factors including intimate ties, social support, and encouragement from others.

The coping model that focuses central attention on active problem solving suggests very different emphases in working with many types of patients than a psychodynamic perspective would encourage. It argues for giving attention to the way patients deal with routine everyday events and for utilizing educational approaches to assist patients in coping more adequately. Treatment programs for chronic mental patients based on such conceptions have reported considerable success in rehabilitation relative to more conventional models of management of such patients (Stein and Test, 1978).

Social functioning depends on social expectations and on the extent to which activity, initiative, and responsibility are encouraged. The literature on custodial mental hospitals, as well as other custodial institutions, demonstrates that long-term confinement, institutional dependence, and inactivity results in a range of secondary disabilities and erosion of skills and interpersonal associations (Goffman, 1961; Wing, 1962; Wing and Brown, 1970). Patients become apathetic, feel hopeless, and lose the ability to deal with ordinary problems of living. They also increasingly lose attachments to others and become isolated from patterns of mutual obligation. Although such "institutional neurosis" or "institutionalism" has been widely recognized, the basic effects are in no way limited to institutions, but occur commonly in community settings as well (Segal and Aviram, 1978; Estroff, 1981). Our knowledge of the settings that best promote functioning and satisfaction among chronically impaired patients still remains fragmentary, and we need much more specific knowledge of the way particular settings relate to specific types of handicap.

In Conclusion

I have taken you through a highly selective examination of the relevance of sociological research and theory for understanding mental disorder, neglecting many important areas.

In summary, sociological theory and research contributes to understanding not only social aspects of mental disorder, its progression, and its consequences, but also those forces that influence the way the mental health professions are organized and how they perform their various responsibilities.

REFERENCES

Angrist, S., Lefton, M., Dinitz, S., and Pasamanick, B., 1961, Tolerance of Deviant Behaviour, Posthospital Performance Levels, and Rehospitalization, in "Proceedings of the Third World Congress of Psychiatry," Volume 1, Montreal, pp. 237-241.

Brown, G. W., Bone, M., Dalison, B., and Wing, J. K. 1966, "Schizophrenia and Social Care:A Comparative Follow-up Study of 339 Schizophrenic Patients," Oxford University Press, New York.

Brown, G. W., and Harris,T., 1978, "Social Origins of Depression: A Study of Psychiatric Disorder in Women," The Free Press, New York.

Clausen, J., and Yarrow, M.R.,(eds.), 1955, The Impact of Mental Illness on the Family, J Soc Iss, 11 #4, entire issue.

Clausen, J., Pfeffer, N.G., and Huffine,C., 1982, Help-Seeking in Severe Mental Illness. "Symptoms, Illness Behavior and Help-Seeking," Neale Watson, New York, 135-155.

Coelho, G. V., Hamburg, D.A., and Adams, J. E., (eds.), 1974, "Coping and Adaptation," Basic Books, New York.

Dohrenwend, B. P. and and B. S. Dohrenwend, 1969, "Social Status and Psychological Disorder: A Causal Inquiry," Wiley-Interscience, New York.

Durkheim, E., 1951, "Suicide: A Study in Sociology," The Free Press, Glencoe, Ill.

Estroff, S. E., 1981, "Making It Crazy: An Ethnography of Psychiatric Clients in An American Community," University of California Press, Berkeley.

Freeman, H. E., and Simmons, O.G., 1963, "The Mental Patient Comes Home," John Wiley & Sons, New York.

Goffman, E., 1961, "Asylums: Essays on the Social Situation of Mental Patients and Other Inmates," Doubleday-Anchor, Garden City, N.Y.

Gove, W. R., 1970, Societal Reaction As An Explanation of Mental Illness: An Evaluation, Amer Soc Rev, 35(October):873-884.

Gove, W. R., 1978, Sex Differences in Mental Illness among Adult Men and Women: An Evaluation of Four Questions Raised Regarding the Evidence on the Higher Rates of Women, Soc Sci and Med, 12(July):187-198.

Gove, W. R., and Tudor, J.F., 1973, Adult Sex Roles and Mental Illness, Amer J Soc, 78(January):812-835.

Greenley, J. R., 1972, The Psychiatric Patient's Family and Length of Hospitalization, J of Health and Soc Behav, 13(March):25-37.

Hollingshead, A. B., and Redlich, F.C., 1958, "Social Class and Mental Illness: A Community Study." John Wiley & Sons, New York.

Kadushin, C., 1962, Social Distance between Client and Professional, Amer J of Soc, 67(March):517-531.

Kadushin, C., 1969, "Why People Go to Psychiatrists," Atherton, New York.

Kaplan, B. H., Cassel, J.C., and Gore,S., 1977, Social Support and Health, Med Care, 15 (May,):47-58, Supplement.

Kohn, M. L., 1972, Class, Family, and Schizophrenia: A Reformulation, Soc Forces, 50(March):295-304.

Kohn, M. L., 1977, "Class and Conformity: A Study in Values," 2nd ed., University of Chicago Press, Chicago.

Kulka, R. A., Veroff, J.,and Douvan, E., 1979, Social Class and the Use of Professional Help for Personal Problems: 1957 and 1976, J of Health and Soc Behav, 20(March):2-17.

Lazarus, R. S., 1966, "Psychological Stress and the Coping Process," McGraw-Hill Book Company, New York.

Mechanic, D., 1974, Social Structure and Personal Adaptation: Some Neglected Dimensions, in Coelho, G.V., Hamburg, D.A., and Adams, J.E. (eds.), "Coping and Adaptation," Basic Books, New York, pp. 32-44.

Mechanic, D., 1977, Illness Behavior, Social Adaptation, and the Management of Illness: A Comparison of Educational and Medical Models, J of Nerv and Men Dis, 165 (August):79-87.

Mechanic, D., 1978a, "Medical Sociology," 2nd ed., The Free Press, New York.; first published in 1968 by The Free Press.

Mechanic, D., 1978b, Explanations of Mental Illness: An Editorial, J of Nerv and Men Dis, 166(June):381-386.

Mechanic, D., 1978c, Sex, Illness, Illness Behavior, and the Use of Health Services, Soc Sci and Med, 12(July):207-214.

Mechanic, D., 1978d, "Students under Stress: A Study in the Social Psychology of Adaptation," The University of Wisconsin Press, Madison.

Mechanic, D., 1979, Development of Psychological Distress among Young Adults: A Theoretical Hypothesis and Results from a 16-Year Follow-up Study, Arch of Gen Psych, 36(October):267-274.

Mechanic, D., 1980, "Mental Health and Social Policy," 2nd ed., Prentice-Hall, Englewood Cliffs, N.J.; first published in 1969 by Prentice Hall.

Merton, R. K., and Nisbet, R.A.,(eds.) 1961, "Contemporary Social Problems: An Introduction to the Sociology of Deviant Behavior and Social Disorganization," Harcourt, Brace & World, New York.

Murphy, H.B.M. and Raman, A.C. 1971, The Chronicity of Schizophrenia in Indigenous Tropical Peoples: Results of a Twelve-Year Follow-up in Mauritius, Brit J of Psych, 118:489-497.

Myers, J. K., and Schaffer, L., 1954, Social Stratification and Psychiatric Practice: A Study of an Out-Patient Clinic, Amer Soc Rev, 19(June):307-310.

Nisbett, R. E., and Valins, S.,1971, Perceiving the Causes of One's Own Behavior, in Jones, E.E., Kanouse, D.E., Kelley, H.H., Nisbett, R. E., Valins S. and Weiner, B.(eds.) "Attribution: Perceiving the Causes of Behavior," General Learning Press, Morristown, N.J., pp. 63-78.

Newmann, J., 1982, "Sex Differences in Depression: A Test of Alternative Explanations for the Greater Vulnerability of Women to Depression," Doctoral Dissertation, Madison: University of Wisconsin.

Robins, L. N., 1966, "Deviant Children Grown Up: A Sociological and Psychiatric Study of Sociopathic Personality," Williams and Wilkins, Baltimore.

Robins, L. N., 1975, Alcoholism and Labelling Theory, in Gove, W.R., (ed.) "The Labelling of Deviance: Evaluating a Perspective," Halsted Press, New York, pp. 21-33.

Robins, L. N., 1979, Follow-Up Studies of Behavior Disorders in Children, in Quay H.C. and Werry, J.S. (eds.) "Psychopathological Disorders of Childhood," 2nd ed., Wiley, New York.

Rosenhan, D.L., 1973, On Being Sane in Insane Places, Science, 179 (January, 19,):250-258.

Scull, A. T., 1977, "Decarceration: Community Treatment and the Deviant," Prentice-Hall, Englewood Cliffs, N.J.

Segal, S. P., and Aviram, U. 1978, "The Mentally Ill in Community-Based Sheltered Care: A study of Community Care and Social Integration," Wiley-Interscience, New York.

Stein, L. I., and Test, M.A. (eds.), 1978, "Alternatives to Mental Hospital Treatment," Plenum Press, New York.

Stone, A. A., 1975, "Mental Health and Law: A System in Transition," DHEW Publication No. (ADM) 75-176, National Institute of Mental Health, Center for Studies of Crime and Delinquency, Rockville, Md.

Szasz, T. S., 1974, "The Myth of Mental Illness: Foundation of a Theory of Personal Conduct," rev. ed., Harper and Row, New York.

Turner, R. J., and Wagenfeld, M.O., 1967, Occupational Mobility and Schizophrenia: An Assessment of the Social Causation and Social Selection Hypotheses, Amer Soc Rev, 32(February):104-113.

Waxler, N.E. 1979, Is Outcome for Schizophrenia Better in Non-Industrial Societies? The Case of Sri Lanka, J of Nerv and Men Dis, 167:144-158.

Weissman, M. M., and Klerman, G.L., 1977, Sex Differences and the Epidemiology of Depression, Arch of Gen Psych, 34(January):98-111.

Wing, J.K., 1962, Institutionalism in Mental Hospitals, Brit J of Soc and Clin Psychol, 1(February):38-51.

Wing, J.K., and Brown, G.W., 1970, Institutionalism and Schizophrenia: A Comparative Study of Three Mental Hospitals, 1960-1968, Cambridge University Press, Cambridge.
World Health Organization, 1979, "Schizophrenia: An International Follow-Up," John Wiley, Geneva, New York.

SOCIOLOGY OF PSYCHIATRIC CARE SYSTEMS

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To speak briefly on the sociology of psychiatric care systems is only possible if we confine ourselves to a few of the essential problems. The characteristics of these systems are of course closely related to the type of society in which they are used, and we will refer here only to those with which we are familiar.

Since the psychiatric care systems we are familiar with are often proposed or chosen as models in other parts of the world, the following considerations could be of value for psychiatrists and mental health specialists in many countries.

THE COMMUNITY MENTAL HEALTH CENTRE

The system of psychiatric care recommended since the 1960s in the major industrialized countries is usually called community psychiatry. It is known in France as sector psychiatry. In this system, a community mental health centre becomes the basic element in the treatment and prevention of mental disorders. Nevertheless, in most of these countries private and public psychiatry exist side by side, and there are many voluntary associations active in the mental health field. These sectors sometimes work closely together, and sometimes they do not.

Unlike the traditional psychiatric hospital, the community mental health centre is supposed to meet a number of requirements. It is situated where the people live and is responsible for all the mental health problems occurring in a defined catchment area. Together with inpatient services, it provides a spectrum of outpatient and community services which enable the patient to receive treatment

without leaving his usual environment. The provision of these services by a multidisciplinary team leads to continuity of care. The community mental health centre is committed to prevention as well as treatment and social rehabilitation. To fulfil its functions, it works in close collaboration with the other health and social support systems.

When the patient needs to be hospitalized, this hospitalization is kept to the minimum and takes place more and more often in the psychiatric unit of a general hospital. The creation within the general hospital, or elsewhere, of various psychiatric services, making it possible to deal with crisis situations at any hour of the day or night, also helps to avoid longer hospitalization.

The introduction in psychiatric therapy of psychotropic drugs which can act effectively on delusions, severe affective disorders and anxiety, and which can be used by outpatients, has contributed strongly to the avoidance of long-term institutional care for many patients with severe mental disorders.

To be really effective, community mental health centres need the active participation of the patient and the help of those around him, as well as that of the larger community.

POSSIBLE CONSEQUENCES OF COMMUNITY PSYCHIATRY

Shifting the centre of the care system from the psychiatric hospital to the community mental health centre can have several consequences which do not serve the patients' interests.

The deinstitutionalization of the chronically mentally ill, whose outpatient care calls for the provision of new services, runs the risk of failure unless there is some assurance that the community is prepared to live with them and meet their needs.

Taking care of all the mental health problems in a given population requires a much broader range of services than provided by traditional facilities. Some prevention and rehabilitation activities are clearly outside the scope of health. This broadened range accordingly reduces the share of attention available for psychiatric demands and therapy. This trend may result in the provision of services that are more of a social than of a medical nature.

The use of multidisciplinary teams, in which clinical psychologists, social workers, nurses, educators and occupational therapists work more and more with the psychiatrists, sometimes leads to a situation of excessive demedicalization.

These tendencies are intensified by inadequate resources. All

too often, the centres cannot achieve their ambitions because their means are insufficient. This frequently prevents them from providing recently deinstitutionalized patients with appropriate treatment and decent living conditions.

COMMUNITY TOLERANCE AND DENIAL OF PSYCHIATRIC REALITY

As was pointed out earlier, the community care of mental patients demands that those around them and the society as a whole should be willing to meet their needs. It should not be forgotten that originally asylums were created, as their name implies, as shelters in which "lunatics" would be protected from the mistreatment to which they were exposed and given the care and assistance due to them from society, as soon as the pathological nature of disorders of the mind was recognized. If we wish to close down the large psychiatric institutions where patients become chronically ill and are cut off from society, we must create substitutes which will provide protection for those who are too ill to take care of themselves.

Although psychiatry and mental health have made considerable progress, it is not certain that the actual tolerance for the mentally ill, the marginals and the deviants is greater to-day than it was in former times. Furthermore, the living conditions of modern society certainly make it harder for many of them to adjust to their family, their working environment and their social group.

Another danger is that of denying the unbearable nature of some disorders, the aggressiveness or destructiveness of some patients and the detrimental effects of their maintenance in the community on the mental health of those around them. Such effects are especially frequent when the necessary care and support are inadequate.

An idealized vision of community psychiatry can thus place upon the lives of other household members, friends, neighbours and the society as a whole, a burden which they justifiably find too heavy. It then leads inevitably to negative attitudes and rejection of the patients, and furthermore puts psychiatry in danger of being itself rejected by society.

INDICATIONS FOR PSYCHIATRIC HOSPITALIZATION

Many mental health specialists to-day forget that the hospitalization of mental patients in a specialized setting is still indicated in certain circumstances, and that inpatient services constitute an essential part of every mental health care system.

As Gruenberg has pointed out, several major benefits from hospitalizing mental patients can be identified : their safety,

making a diagnosis, beginning a treatment, meeting a need for shelter, providing temporary relief for the people they live with, helping them realize that their troubles are of a pathological nature and that there is a possibility of treating them.

In some cases, the patient is unable to co-operate and only involuntary commitment can ensure his or others' safety, but if the necessary time is taken to convince them, most patients will accept hospitalization voluntarily. Certain diagnostic procedures can require continuous observation for several days. Chemotherapy often has to be prescribed in high doses, and the nature of the disorder itself can call for isolation. It may be necessary to withdraw the patient from the constraints and stress of everyday life that overwhelm him. In cases in which the patient is a heavy burden on those he lives with, hospitalization can prevent the deterioration of his relationships with the occurrence of negative attitudes and aggressive reactions of rejection which, once they have been established, tend to be irreversible. Finally, in some cases, only hospitalization, judiciously used to this end, will enable the patient to acquire a deeper insight on his condition, accept the need for psychiatric help and realize that there are treatment facilities which are at his disposal if necessary.

THE NEED FOR PROTECTIVE RESIDENTIAL FACILITIES

Apart from the cases in which hospitalization is indicated, many chronic mental patients, unable to face the necessities of their daily life and without family or friends prepared to support them, should have the possibility of being helped and protected in adequate residential facilities while receiving outpatient care.

Of course, there are great social disparities in these cases. Some privileged patients, provided their family agrees to it, which is far from always being the case, are able to lead a very protected life. For others, the vast majority, because of the considerable cost of their needs, it is the larger community that has to provide the means for their support.

Without these means, the number of chronic mental patients and invalids who are more or less left to their fate can only increase and contribute to the ever growing population of homeless people. In the presence of some cases, one may come to regret that the life of an inmate they would have had in former times is no longer available.

Modern psychiatry is making two contradictory mistakes. On the one hand, it seeks to extend its field of interest to psychosocial problems which it is unable to solve, and on the other hand, it tends to deny or minimize the harsh reality of mental pathology.

THE MENTAL HANDICAP

In recent years a number of countries have adopted legal measures aimed at providing assistance for all categories of handicapped people. The mentally handicapped represent, of course, a significant number of the people receiving assistance. Classifications are proposed, all based on the concepts of impairment and disability. In my opinion, they do not sufficiently take into account the specific nature of mental pathology. A psychopathological state does not amount only to a loss of mental functioning. The human mind has the capacity to overcome its deficiencies, to develop new modes of mental balance and even to use distressing experiences creatively.

Another important problem is that the increasing use of computerization makes it necessary for modern society to protect its mental patients against the dangers to which they are exposed by the possible interconnection of computer records.

Consequently, while maintaining its objective of providing assistance where needed, society should give priority to helping mental patients make the best use of their aptitudes and avoid conferring on them, without the necessary caution, the status of mentally handicapped.

CONCLUSION

The success or failure of community psychiatry will depend to a large extent on whether these considerations are taken into account.

Mental patients risk being inadequately cared for and not living decently if, on the one hand, mental health centres, for want of sufficient psychiatric orientation, are led increasingly to neglect them and if, on the other hand, the community, for want of appropriate means, sufficient education and a realistic assessment of what is acceptable, is led increasingly to reject them. Hospitalization of mental patients is still indicated in several instances, though obviously not in outmoded conditions. It must never be forgotten that in many cases, community care is only feasible where protective residential and living conditions are available. Finally, and this is a fundamental point, mental patients recently freed run the risk of finding themselves chained in new ways if the status of mentally handicapped stigmatizes and isolates them again.

NOTES ON THE RELEVANCE OF SOCIOLOGY FOR PSYCHIATRY IN LATIN AMERICA: THE CASE OF CALI, COLOMBIA

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I. INTRODUCTION

It is only in the last decades that Latin American countries have begun to design community mental health programs which represent an alternative to the traditional custodial model of psychiatric institutions. At present, several countries share a preoccupation to incorporate mental health plans into the general public health programs and it is precisely in this endeavor where social sciences may be particularly useful for better exploring the characteristics of populations, their attitudes, opinions and practices; their notions about mental disorders and their treatment; their demands to the services and the reciprocal expectations of the service providers.

As part of a wider effort to assess the health needs of the region and to test the feasibility of new programs, the Department of Psychiatry at Universidad del Valle in Cali, Colombia conducted several interdisciplinary research projects in the field of community mental health as related to social factors and this paper will be based on some of their findings. However, it may be useful to first offer a brief description of the place and its characteristics. Cali is a city which at the time of the studies quoted below had a population of about one million inhabitants. It is localted in the South Western part of Colombia in the fertile Cauca river valley a region regarded as exceptionally well suited for agricultural purposes. Due to a steady flow of rural-urban migration, Cali has experienced a phenomenal growth during the last years, but in spite of increasing industrialization, the region is economically dependent on agriculture and most specifically on sugar cane cultivation. As it is typical of most of the semi-industrialized cities in Latin

America one can observe great contrasts between the life styles of an afluent minority and the big mass of the poor, between the two of which an emergent middle class is making itself visible. Opportunities for education and occupational mobility are quite limited and the normative structure is based on the traditional Latin American culture, with family relations as the institutional axis for social organization.

II. COMMUNITY IMAGES OF MENTAL DISORDER

The following is a summary view of some of the findings obtained in several interdisciplinary studies focusing on issues of common concern to sociology and psychiatry.

In a study about community opinions on mental disorder and its treatment in Cali[1] using a stratified random sample of 800 people, the respondents show themselves relatively ignorant about causes and characteristics of mental disorder but they evidence a marked tendency to conceive mental disorders as caused mostly by physical factors. In fact, 50% of the respondents attribute mental disorders to physical causes, 27% to psychological causes and 14% to social causes. Physical manifestations are stated as a characteristic of mental disorder by 17% of the informants. A linguistic survey on terms used popularly to designate a psychotic person[2] also found that mental disorder is primarily conceived as a physical factors was more frequent in the lower class, whereas respondents in the middle class showed a tendency to invoke social causes and those in the upper class favored psychological factors.

A comparison of responses obtained in the survey of the general population[1] with those from a sample of 333 representing several types of medical and para-medical personnel[3] shows that doctors also tend to conceive mental disorder in somatic terms. Graduate nurses often mention psychological causes while auxiliary nurses, social workers and psychologists favor social causes.

General population respondents also show a high degree of confidence in the professional ability of psychiatrists to treat mental disorders, (92% positive answers) as well as a good opinion about the psychiatric hospital[1].

In a study designed to explore feelings and attitudes of rejection of the mentally ill in Cali[4], it was found that only 50% of the respondents would not accept an ex-patient of the psychiatric hospital as next door neighbour; 12% would not accept him or her as work mate and 52% would reject him or her as spouse. These proportions are lower than any other quoted in the literature, with the exception of those found in a study conducted in Costa Rica[5].

In regards to notions about how mental disorder is distributed

in Cali, respondents in the aforementioned sample of medical and para-medical personnel[6] offered the following global opinions: insanity is more frequent in the female sex according to 46% of the respondents; equally distributed among the two sexes according to 27%; more frequent among men according to 22% of the respondents and 5% do not know. Most of the respondents estimate that the age of onset for mental disorders is around 20 years. In regard to social class, 39% of respondents believe that insanity is more frequent in the lower classes; 32% more frequent in the middle class; 7% more frequent in the upper class; 10% believe it is equally distributed among the 3 classes and 12% do not know. Opinions about the rate of prevalence for psychosis in Cali show wide variability with an average for the whole sample of about 11%. Global opinions about the proportion of persons under the care of the respondents who suffer with emotional problems gives an average of 46%. Asked to define the proportions of different psychiatric condition, seen in their patients respondents give the following global averages: 49% free of mental disorders; 47% with neurotic, psychosomatic or personality problems and 8% with psychotic disorders. A general comment that can be made on these findings is that the figures given are quite similar to those obtained in epidemiological studies in Latin America, especially in regards to distribution according to age, sex and social class.

One of the most persistent challenges for research in social sciences is to evaluate the consequences on individuals of change in living conditions. While it is generally admitted that mobility necessary to generate mental disorders.

In an effort to analize the effects of geographic and social mobility, a sample of 681 persons representing people in the labor force in Cali were interviewed and assessed[7]. A detailed occupational and residencial history was obtained from each respondent together with a typology of migration and mobility. Each case was also evaluated as to presence of absence of mental disorder by means of the Langner 22 items questionnaire[8]. The distribution of symptoms scores shows a range from 0 to 19 with mean of 6.3, and the mean for women is three points higher than that for men, which corroborates the finding of a higher prevalence of symptoms in Latin American populations as compared to those of North America[9]. The mean symptom score is consistantly higher for persons with lower levels of education. In regard to social mobility the only significant difference is found for informants of low occupational status similar to that of their parents. When migratory status is analized separately the highest mean symptom score is found for migrants who come from rural areas, as compared with those of no migrants or migrants coming from other urban areas. This finding is suggestive that previous experience in adapting to populous communities increases the ability to face urban life stress. However, when all variables are analized simultaneously by means of multivariate techniques,

(factorial analysis, multiple regression) the influence of migration on symptom scores virtually disappears in front of the importance of sex, education and type of social mobility as determining factors. Women with low level of education appear as the most vulnerable group, but upward social mobility, seems to atenuate this vulnerability while downward mobility increases it.

A study of the patterns of hospitalization of mentally ill people in Cali[10] in which social and demographic factors were evaluated together with clinical characteristics shows that patients with the same diagnoses and similar clinical picture were assigned alternatively to outpatient clinics or to inpatient care in concordance with attitudes and opinions of patients' relatives and their readiness to care for them at home. Almost all patients who where hospitalized came to the hospital accompanied by relatives and in 75% of cases the relatives opined that the patient was crazy. Likewise, the attitudes exhibited by the patient towards relatives and doctors were significantly associated with the type of care prescribed.

The role of families in the process of hospitalization for mental disorder appears to be a crucial one. A similar role may be played in the course and outcome of severe mental disorders such as Schizophrenia. One of the most striking findings of the 2 year follow-up of patients seen in the W.H.O. International Pilot Study of Schizophrenia[11] was a significant difference in the outcome of patients from the developing countries as compared to those of the developed industrial countries. Differences in family cohesion and family attitudes may be associated with the process and need to be further elucidated.

III. COMMENTS

Referring to the different findings in the same order of their presentation, the following succint comments can be made:

Both among the general population and groups of health workers there is a predominant tendency to attribute physical causes to mental disorders. This suggest the presence of a common underlying notion which is part of the cultural systems of beliefs, even though a certain proportion of informants recognizes the role of psychological and social factors. An important practical application of this finding would be the use of existing general public health programs for incorporating mental health care activities and also the development of training programs for health personnel which may include knowledge about the role of psychological and social factors on health problems. The implementation of community primary health care programs, including mental health, and the use of multiaxial systems of classification of health problems appear as desirable goals for increasing the

effectiveness and efficiency of community mental health programs.

The finding of a favorable disposition of the general public towards mental expatients, points to the possibility of conducting useful community programs of education in mental health and rehabilitation of the mentally ill. The positive concepts expressed by the public about psychiatrists and psychiatric treatment reinforce this possibility.

The study of the role of migration and social mobility in relation to mental disorder show the importance of education and sex as significant associations. Belonging to the female sex and having a low level of education appear as a risk factors for mental disorder. This may have an important implication for initiating preventive activities. Social reforms aiming at improvement of the status of women and increment of opportunities for advance in education and work could effectively contribute to improving the mental health prospects of the groups at risk.

The role of the family in the generation, course and outcome of mental disorders deserves special attention. Several studies point to the decline of family influence due to factors such as urbanization, industrialization and migration but an alternative possibility has been vigorously suggested in a review of Latin American studies[12]. The authors offer suggestive evidence of the help offered by family networks for reducing the negative impact of migration and for facilitating upward social mobility. It seems as if family cohesion and the availability of a network of relatives ready to intervene in crisis situations may be crucial factors for determining the clinical course and outcome of mental disorders as well as their prevention and rehabilitation.

REFERENCES

1. C.A. León and M. Micklin. Opiniones comunitarias sobre enfermedad mental y su tratamiento en Cali, Colombia. Acta Psiq. Psicol. Am. Lat. 17:385 (1971).
2. M. Micklin, M. Durbin, C.A. León. The lexicon for madness in a Colombian city: An exploration in semantic space. Am. Ethnologist 1:143 (1974).
3. M. Micklin and C.A. León. Colombian views on causes and treatments for mental disorder: A comparative analysis of health workers and the public. Social Psychiatry 12:133 (1977).
4. M. Micklin and C.A. León. Rechazo al enfermo mental en una ciudad sudamericana: Un análisis comparativo. Acta Psiquiat. Psicol. Am. Lat. 18:321 (1972).
5. G. Adis-Castro and F.B. Waisanen. Lugar de residencia y actitudes hacia el enfermo mental. Acta Psiquiat. Psicol. Am. Lat. 11:356 (1965).
6. M. Micklin and C.A. León. Perceptions of the distribution of

mental disorders in a South American city. Sociol. Work Occup. 3:273 (1976).
7. M. Micklin and C.A. León. Life change and psychiatric disturbance in a South American City: The effects of geographic and social mobility. J. Health Soc. Behav. 19:92 (1978).
8. T.S. Langner. A twenty-two item screening score of psychiatric impairment. J. Health Soc. Behav. 3:269 (1962).
9. P. Haberman. Ethnic difference in psychiatric symptoms reported in community surveys. Pub. Health Reports 85:495 (1970).
10. C.A. León and M. Micklin. Who shall be hospitalized? Some social and psychological correlates of alternative dispositions of the mentally ill. Acta Psychiat. Scand. 58:97 (1978).
11. World Health Organization. "Schizophrenia - An international follow-up study." John Wiley & Sons. Chichester (1979).
12. M. L. Carlos and L. Sellers. Family, kinship structure and modernization in Latin America. Lat. Am. Research Rev. 7:95 (1972).

SOCIAL RELATIONSHIPS AND THE ONSET OF DEPRESSIVE DISORDERS: THE LIMITATIONS OF SOCIAL VARIABLES FOR AETIOLOGICAL RESEARCH

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Psychiatric epidemiology, in its search for aetiological clues, has lent heavily on notions taken from sociological theory, though there is little evidence that this has been to its benefit. It has moved from an elementary level, where differences in prevalence were described between coarse sociodemographic groups, to analytic epidemiology where the immediate goal has been to identify risk factors.

It cannot really be claimed that psychiatric epidemiology has enjoyed an abundance of hypotheses. All of the main ones have been in the social or experiential domain, suggesting that the discipline is uncomfortably paradigm-bound. The main rubrics for these hypotheses have been as follows: maternal deprivation; socio-cultural disintegration; bereavement; life-events; and now social networks and social support. All of these hypotheses place the pathogenic element outside the individual, though from time to time the possible relevance of individual variation in vulnerability to these insults may be acknowledged.

The yield of information has been more in gaining an understanding of the technical challenges in such research, than it has in acquiring a body of knowledge about aetiology. Thus, when the scholarly work of Bowlby (1969, 1973, 1980) gave rise to some rich hypotheses about the short and long term effects of maternal deprivation, a great deal of technical experience was eventually achieved as investigators found that the concept was by no means unitary; and that many other variables in the child, the mother, the context and the subsequent environment, brought about major variations in the experience itself. Again, workers came to realise the unsuitability of using only clinical or other treated

samples in their case-control designs. For the long term effects of parental death in childhood on adult vulnerability to depression, careful reviews of the evidence by Tennant and his colleagues (Tennant et. al. 1980, 1981, 1982) lead them to conclude that parental death on its own has little impact upon the risk of depressive illness in adult life. As for other forms of parental deprivation, it is technically extremely difficult to obtain reliable measures of these retrospectively. Unless some group undertakes a prospective longitudinal study, it seems to me unlikely that any sound data will become available for adequate testing of other hypotheses about parental loss.

In work on socio-cultural disintegration, as pioneered by the Leightons (Leighton AH et al., 1963; Leighton DC et al., 1963), it has proved very hard to disentangle the complex independent variables from the dependent variable of psychiatric morbidity. All too commonly, there has been no diagnostic specificity about the latter, but instead an examination of mental disorder in general. Again, there has always been the problem of confounding of measures of socio-cultural integration with long standing personality attributes. The area seems an unlikely one for fruitful research in the future.

Work in the last 20 years on morbidity following bereavement suggests that there may be some increase in help-seeking behaviour, and possibly in depression, particularly in younger widows; but Clayton (1979) reviewed prospective studies to conclude that, although conjugal bereavement is a psychologically stressful event, the great majority cope with the loss with minimum morbidity and mortality. Where there are effects, they seem to be weak, particularly in older persons.

Then there has been research on life events. It has become almost an industry in its own right. Expressed as relative risk, such experiences do seem to cause some increase (Paykel, 1978) For depression, this has been found to be between 4 and 6.5, though the amount of variance explained is no more than 10% or less in the best prospective studies. Interest has been turning to modifying variables, both within the individual and the social environment, which might account for the very great individual variation in the effects of adversity (Andrews et al., 1978; Paykel, 1978); Kobasa et al., 1981; Turner et al., 1981).

Very recently, a new social hypothesis has emerged. This probably stems from the work of Bowlby (1969), AH Leighton (1963) and Cassel (1976). The latter, in his paper "The Contribution of the Social Environment to Host Resistance" captured the essence of the central hypothesis in this title: that social support may act as a buffer or cushion against the impact of life stresses, thereby reducing morbidity. A separate hypothesis is that a lack

of social support has a direct pathogenic effect for neuroses or minor depressive disorder. With good reason, much effort has been put into the construction of interview instruments for the measurement of social relationships and social support (Weissman et al., 1981). Reasonably satisfactory instruments have been developed by McCallister and Fischer (1978). Details of our own instrument, constructed specifically for psychiatric research, were published in "Neurosis and the Social Environment" (Henderson et al., 1981). As Sarason (1980) nicely puts it "The concept of social support seems important, yet vague". In the last three years, you will find a number of papers producing evidence that the lack of social support is associated with increased morbidity (Eaton, 1978; Pearlin et al., 1981; Holahan and Moos 1981; Aneshensel and Stone, 1982; Aneshensel and Frerichs, 1982). After conducting an optimistic review of the therapeutic value of social networks for mental health, Greenblatt et al., (1982) have gone on to advocate intervention strategies using social support. Two important studies in medical epidemiology indicate that low social support is associated with increased mortality (Berkman and Syme, 1979) and an increased prevalence of coronary heart disease (Reed et al., 1983). These findings deserve close attention.

My own research group believes that the interpretation of such findings is very far from conclusive; and we would advocate much greater scepticism before the next juggernaut in social psychiatry starts its journey. For clinical and administratively relevant information, the following minimal requirements have to be met for research in this area:

1. The hypotheses being tested must be clearly distinguished. One hypothesis is that the lack of social support is independently a causal factor in the onset of depressive disorder or other diagnostic categories;

2. A second is that social support is protective in the presence of adversity. This is an interactional model.

3. A third hypothesis is that social support influences the course of specified psychiatric disorders once they are established, presumably for the better. This would certainly be in keeping with the therapeutic effect of some personal relationships, as Frank (1973) has indicated.

4. Any measures of social support must not be confounded with personality measures of the individual, related to his or her competence in what Foulds (1965) termed "establishing and maintaining mutually satisfying personal relationships".

Our own published data, which is based on a prospective longitudinal study of a general population sample and is therefore uncontaminated by selection factors related to illness behaviour, failed to confirm the hypotheses with which we started. We expected social relationships to have a protective effect against minor depression and neuroses; or for the lack of them to have a direct pathogenic effect. Instead, the indices derived from the Interview Schedule for Social Interaction (ISSI) which systematically examines an individual's personal network and his satisfaction with it, lead us to conclude that it is not the individual's social environment which is likely to have a substantial causal effect, but how he or she construes it. That is, intrapersonal variables are more powerful predictively than social environmental ones. One simple diagram makes this clear.

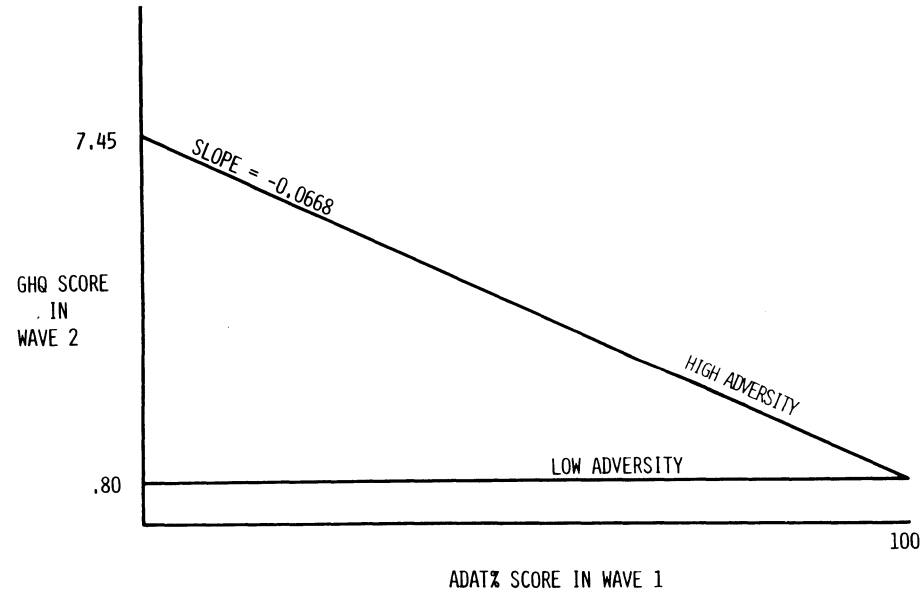

Figure 1

The availability of intimate relationships had no effect in increasing the risk of subsequent morbidity; but the perceived adequacy had a substantial effect. Furthermore, this was not on its own but only when adversity was also present. The measures of perceived adequacy of social relationships behave very much like personality measures and indeed correlate substantially with neuroticism and affiliative drive.

Such data obtained from a prospective epidemiological study lead one to suspect that for aetiological work in psychiatry, sociological hypotheses are seriously unsatisfactory; and that, after a lengthy excursion into the social environment during the last 30 years, researchers should now turn their attention again towards measures of temperament and other properties of the individual, including biological ones. Many psychiatrists, being regrettably paradigm-bound, will inevitably cling to social and experiential models, but I predict that their numbers will dwindle. The psychoanalyst Guntrip (1974) put the situation clearly: "Thus by projection and introjection human beings live in two worlds at once, the inner mental world and the external material world, and constantly confuse the two together". But it is the task of the clinician and research worker to disentangle these two worlds. Psychiatric epidemiology is now well equipped to contribute to this if it is prepared to include measures of biological and intrapersonal variables in its enquiries. An excessive preoccupation with social variables and sociological concepts has only slowed up the acquisition of useful information about aetiology.

REFERENCES

ANDREWS, G. & TENNANT, C. (1978) Life events, stress and psychiatric illness: a review. Psychological Medicine, 8, 545-549.

ANESHENSEL, C.S. & FRERICHS, R.R. (1982) Stress, support, and depression: A longitudinal causal model. Journal of Community Psychology, 10, 363-376.

ANESHENSEL, C.S. & STONE, J.D. (1982) Stress and depression. Archives of General Psychiatry, 39, 1392-1396.

BOWLBY, J. (1969) Attachment. Attachment and Loss, 1, Hogarth Press, London.

BOWLBY, J. (1973) Separation: anxiety and anger. Attachment and Loss, 2, Hogarth Press, London.

BOWLBY, J. (1980) Loss, sadness and depression. Attachment and Loss, 3, Hogarth Press, London; Basic Books, New York.

CASSEL, J. (1976) The contribution of the social environment to host resistance. American Journal of Epidemiology, 104, 107-123.

CLAYTON, P.J. (1979) The sequelae and nonsequelae of conjugal bereavement. American Journal of Psychiatry, 136, 1530-1534.

EATON, W.W. (1978) Life events, social supports, and psychiatric symptoms: a re-analysis of the New Haven data. Journal of Health & Social Behavior, 19, 230-234.

FOULDS, G.A. (1965) Personality and Personal Illness. Tavistock Publications, London.

FRANK, J.D. (1973) Persuasion and Healing. Johns Hopkins University Press, Baltimore.

GREENBLATT, M., BECERRA, R.M. & SERAFFTINIDES, E.A. (1982) Social networks and mental health: an overview. American Journal of Psychiatry, 139, (8), 977-984.

GUNTRIP, H. (1974) Psychoanalytic object relations theory. American Handbook of Psychiatry, 1, (Arieti, S. Ed). Basic Books, New York.

HENDERSON, S., BYRNE, D.G. & DUNCAN-JONES, P. (1981) Neurosis and the Social Environment. Academic Press, Sydney, London and New York.

HOLAHAN, C.J. & MOOS, R.H. (1981) Social support and psychological distress: a longitudinal analysis. Jouranl of Abnormal Psychology, 90, (4), 365-370.

KOBASA, S.C., MADDI, S.R. & COURINGTON, S. (1981) Personality and constitution as mediators in the stress-illness relationship. Journal of Health and Social Behaviour, 22, 368-378.

LEIGHTON, A.H., LAMBO, T.A., HUGHES, C.C., LEIGHTON, D.C., MURPHY, J.M. & MACKLIN, D.B. (1963) Psychiatric Disorder Among the Yoruba. Cornell University Press. Ithaca, New York.

LEICHTON, D.C., HARDING, J.S., MACKLIN, D.B., MACMILLAN, A.M. & LEIGHTON, A. (1963) The Character of Danger. Basic Books, New York.

McCALLISTER, L. & FISCHER, C.S. (1978) A procedure for surveying personal networks. Sociological Methods and Research, 7, 131-148.

PAYKEL, E.S. (1978) Contribution of life events to causation of psychiatric illness. Psychological Medicine, 8, 245-253.

PEARLIN, L.I., MENAGHAN, E.G., LIEBERMAN, M.A. & MULLAN, J.T. (1981) The stress process. Journal of Health and Social Behaviour, 22, 337-356.

SARASON, I. (1981) Test anxiety, stress & social support. Jouranl of Personality, 49, (1), 101-114.

TENNANT, C., BEBBINGTON, P. & HURRY, J. (1980) Parental death in childhood and risk of adult depressive disorders: a review. Psychological Medicine, 10, 289-299.

TENNANT, C., SMITH, A., BEBBINGTON, P. & HURRY, J. (1981) Parental loss in childhood: relationship to adult psychiatric impairment and contact with psychiatric services. Archives of General Psychiatry, 38, 309-314.

TENNANT, C., HURRY, J. & BEBBINGTON, P. (1982) The relation of childhood separation experience to adult depressive and anxiety states. British Journal of Psychiatry, 141, 475-482.

TURNER, R.J. (1981) Social support as a contingency in psychological well-being. Journal of Health and Social Behaviour, 22, 357-367.

WEISSMAN, M.M., SHOLOMSKAS, D. & JOHN, K. (1981) The assessment of social adjustment. An update. Archives of General Psychiatry, 38, 1250-1258.

MENTAL HEALTH SERVICES RESEARCH

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INTRODUCTION

More than any other component of the health care system, mental health services are exposed to the zeitgeist. There are three main reasons for that:

(1) The conceptualization of some frequently occurring mental health problems, like minor psychiatric disorders, was subject to great variations due to a lack of precisely identifyable units and causes.

(2) For a long time, the therapy of the majority of mental diseases had to do without a rational basis. It is still lacking a technology suited for stabilizing the institutions.

(3) The significance of the social component in the care of psychiatric diseases forces psychiatrists to be opened to social networks and services. As a consequence psychiatry exposes itself to an increased competition with social professions and to the influence of social ideas.

In connexion with such influences, in most of the developed countries mental health care went through two drastic changes during the last two centuries:

(1) the separation of mental hospitals from the parish infirmaries in the course of last century. It was based on reformatory social motives and on the psychiatric idea that patients could be better helped by separating them from a pathogenic environment and by isolating them in the sheltered world of a mental hospital (Häfner, 1979). C.F.W. Roller who successfully propagated the establishment of remote mental hospitals in Europe, concisely argued in Heidelberg in 1831:

> "Every mentally disturbed must be separated from those persons with whom he had relations before. He must be committed to a different place unknown to him. Those who nurse him must be friends to him. In one word - he must be isolated."

(2) Since the middle of this century, we have been taking the opposite direction: the direction of social integration. More and more patients remain in their familiar social environment during psychiatric treatment. More and more chronically mentally ill are cared by complementary services, the majority of which are not subject to control by health services. Without doubt, they are threatened by the same neglect mental hospitals met with in the course of time.

These processes of change caused high expenses to the societies affected. In some countries, avoidable injury was inflicted on a large number of patients concerned.

As Morton Kramer stated in 1980, many developing countries will be confronted with a steeply growing need for mental health services as a consequence of the increasing life expectancy and the sharp increase in age-groups at risk. The means these countries dispose of for covering the growing need are limited. It is therefore necessary to analyse the experiences made by the developed countries with respect to the material and immaterial benefit of the various systems and policies of mental health care, in order to turn them to account for rational planning.

In 1974, the Section Committee on Psychiatric Epidemiology and Community Psychiatry held a symposium on "Alternatives to the mental hospital" in York/U.K. On this occasion, the implementation, functioning and effective-

ness of this important new component of a comprehensive mental health service were analysed (J. K. Wing et al., 1974). In the meantime the processes of change have been going on. In some countries, they assumed the character of a nation-wide social experiment, e.g. the Community Mental Health Center Programm of the U.S.A. or the closure of mental hospitals in Italy. The preliminary analysis of the data from the WHO project on "Mental Health Services in Pilot Study Areas" by J. Henderson (1983) showed great differences in significant indicators of mental health policy in the 17 European countries collaborating in the study.

We, that is the Section Committee on Psychiatric Epidemiology and Community Psychiatry, Heinz Katschnig and I, thought it would be time to organise a symposium on services research dealing with methods and findings in the main fields of change occurring in the mental health care system. The frame of this symposiom has set limits. M. Sabshin and E. Torre will report to us on the two countries, the U.S.A. and Italy, who by law or state initiatives rapidly and drastically changed large parts of their mental health care systems. We shall hear from J. K. Wing and W. an der Heiden about the evaluation of changes professionally planned and gradually implemented, as were carried out in the U.K. and the F.R.G.

The evaluation of important special services set up in the last decades, such as crisis intervention (Katschnig and Cooper) and psychogeriatric services (Mann) will be concluded by David Goldberg's report on cost-effectiveness analysis and finally by David Mechanic's contribution. He will refer on trends in research and social psychiatry.

We express our thanks to all speakers for having accepted our invitation without exception. We do hope that this symposium might contribute to the increased efforts in mental health services research which should be the basis of reasonable planning and the prevention of unreasonable changes.

REFERENCES

Häfner, H., 1979, Die Geschichte der Sozialpsychiatrie in Heidelberg, in: "Klinische Psychologie und Psychopathologie, Bd. 8: Psychopathologie als Grundlagenwissenschaft," W. Janzarik, Hrsg., Ferdinand Enke Verlag, Stuttgart.

Henderson, J., 1983, Consumption of services - European aspects. Paper presented at the EMRC Workshop on "Needed areas of research on long-term treatment of functional psychoses," Bagnaia/Italy, May 9-12.

Kramer, M., 1980, The rising pandemic of mental disorders and associated chronic diseases and disabilities, in: "Epidemiological research as basis for the organization of extramural psychiatry," E. Strömgren, A. Dupont and J. A. Nielsen, eds., Acta Psychiatrica Scandinavica, Suppl. 285, vol. 62, Munksgaard, Copenhagen.

Roller, C. F. W., 1831, "Die Irrenanstalt in allen ihren Beziehungen," C. F. Müller, Karlsruhe.

Wing, J. K. et al., 1974, Alternatives to hospital care, Psychiatric Quarterly, 48:467-577.

MENTAL HEALTH SERVICES IN THE UNITED KINGDOM

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TWO SWINGS OF THE PENDULUM

As in many other countries, the mental health services in the UK were based, until recently, on large mental hospitals, many of which were located several miles from the districts they served. They had begun as small asylums during the early part of the nineteenth century, set up because the conditions of what might be called the 'community care' of those days were appallingly bad. The intention was to establish places of refuge and resocialisation, run according to the educational principles of the Enlightenment, as an alternative to the private madhouses, the 'single care' and the workhouses that were then the only alternatives to vagrant destitution. The standards of humane care, known as 'moral treatment', achieved in the best asylums were not adopted everywhere but they did represent generally accepted ideas and aims.

Nevertheless, before the end of the century even the homely places of refuge had become large institutions and the custodial era had begun. The pendulum had swung past the point of balance.

A second period of reform began in the 1930s and, after an interruption due to the war, resumed in the 1950s with greater intensity. Again, the motivating vision was moral, part of the general feeling that all human beings, whatever their condition, should be regarded as part of the 'community'. Disability and disadvantage should not be amplified by deprivation, segregation and stigma. Many of the tenets of 'moral treatment' were revived under new names - 'rehabilitation', 'resocialisation', 'industrial therapy', 'the therapeutic community' (Bockoven, 1956). The

introduction in the mid-1950s of forms of medication that helped to relieve the acute manifestations of disorders such as schizophrenia, mania and severe depression was a tremendous boost to morale. Together, the use of the new somatic and psychosocial therapies seemed to promise a future in which severe and chronic disabilities would be prevented, with the result that the large institutions would eventually become unnecessary.

The new vision was directed, therefore, towards care outside hospital. The pendulum was swinging back again. It was thought that, with back-up services such as day hospitals, day centres and sheltered workshops, hostels and group homes, out-patient clinics and good welfare arrangements, in-patient treatment would be required only for acute emergencies (which could be looked after in general hospital units) and dementia (which would necessitate special hospital facilities). This was a more comprehensive and more integrated version of the ideals of 150 years earlier.

HEALTH AND PERSONAL SOCIAL SERVICES RESEARCH

Until very recently, it has not been regarded as necessary to evaluate claims made for new services rigorously, systematically and as a matter of routine, in the manner that is accepted as mandatory for new medications or biological treatments. Yet new ideas about services are often more far-reaching in their effects, both for good and for ill, on patients, on relatives, and on society more generally. Part of the trouble is that powerful research designs, such as a properly conducted double-blind controlled trial, are rarely applicable.

A more important difficulty is that there is often a confusion between evaluating methods of helping people solve the problems that arise from mental illness, on the one hand, and evaluating the service or services that 'deliver' these methods of help, on the other. (See paper in Plenary Session PL37). Some psychosocial techniques of helping people are similar, in many ways, to prescribing medication, and can be evaluated in a similar way. Other therapies are difficult to distinguish from the therapist who practises them or, when the treatment takes a complex group form, from the service setting itself. The ultimate confusion arises when a change in a service index (e.g. a decline in the number of hospital beds) is regarded automatically as indicating an improvement or deterioration in treatment or in morbidity.

Service assessment, per se, is concerned with the efficiency, acceptability and economics of treatment delivery, i.e. with aspects such as management, planning, organisation, training and cost-effectiveness. Important as these aspects are, they depend for their significance only on the fact that they determine the

efficiency with which particular methods of treatment or care are given to people who need them.

Descriptive statistics

Designs for evaluation of services can be very useful so long as their limitations are recognised. Descriptive service statistics, particularly if systematically collected and related to a base population, so that rates can be calculated, show up trends and indicate problems for investigation. The trends may be difficult to evaluate, because they describe what is happening, rather than what ought to happen. They are useful only if strict limits are placed on generalisation and the values underlying interpretation are openly stated.

The statistics of mental hospital bed-occupancy provide a case in point. At the end of 1954, there were 344 beds in English mental hospitals per 100,000 of the general population. This was the peak figure. After half a century of fairly regular increase, in 1955 it started to decline and has continued to do so in regular fashion since. See Table 1. The latest available figure, at the end of 1981, was 156 per 100,000 - considerably less than half of the peak rate. (In parenthesis, it should be noted that the total figure is remarkably close to that of France, Germany and Denmark but substantially lower than that of Eire, Northern Ireland, Scotland and Finland.

TABLE 1
English mental hospitals and units.
Resident patients on 31 December, 1966 and 1970-78,
by length of stay. Rates per 100,000 total population

	1 year	1-5 years	5+ years	Total
1966	71	194		265
1970	66	167		233
1971	64	47	116	227
1972	62	44	109	215
1973	62	41	102	205
1974	58	40	96	194
1975	59	39	90	188
1976	58	39	84	181
1977	57	40	78	175
1978	57	39	75	171
1979	57	39	70	167
1980	?	?	?	161
1981	?	?	?	156

N.B. Peak total rate in 1954 was 354 per 100,000

Further information can be provided if the figures are divided by length of stay. Patients resident for less than one year account for about 60 beds per 100,000 of the English population. This figure has not recently shown much decline. Those resident between one and five years (the 'new' long-stay) account for about 40 beds per 100,000 and this figure, too, is static. All the decrease is now taking place in the over-five-year group and this is substantially more often due to death than to discharge.

In former days, it would have been possible to find statisticians confident enough to make projections on the basis of these trends; predicting what would be the position in another 10 or 20 years. The failure of some notable prophesies has made everyone properly cautious nowadays. The questions we ask are: What are the problems that lead to the new accumulation of long-stay patients and is the large mental hospital the best means of delivering the means of solving them? What alternative methods of delivery are there and how can their effectiveness be tested? If they are effective and if they are set up, does the rate of accumulation of 'new' long-stay patients decrease? The same question can be put the other way round: If the number of 'new' long-stay patients decreases, does it mean that those who formerly would have remained in hospital are now better cared for elsewhere? All these questions are open to test and planners need to know the answers.

Case-registers are a useful extension to national statistics because, for specified geographical areas, they provide not only in-patient data but linked data about episodes of many other forms of care as well (see paper in Symposium SO for comments on ethical aspects). They therefore provide much richer sources of ideas for evaluative research. In addition, case-registers throughout Europe are now beginning to adopt common definitions and to provide comparable statistics. This is a most valuable trend.

Small descriptive surveys

Registers provide an opportunity to undertake a second form of valuable, though still necessarily limited, research. This is the small descriptive survey. By sampling from a District register, it is possible to consider a representative group of people in contact with specified services. For example, we have examined a group of people who, for more than one year, had been receiving some form of health or social service recorded on a case-register covering an inner London area. They, their relatives, and the staff looking after them, were interviewed, in order to discover what their needs were and whether these were being met. The results were interesting, not only for the local

District but, taking the known socio-demographic characteristics into account, for other Districts as well (Wing, 1982).

Comparative and controlled designs

More powerful research designs add a comparative, or even a controlled, element. Comparative designs depend upon the accuracy with which samples can be created and matured.

Underpinning the most sophisticated designs there is always an epidemiological basis. Planning for whole populations automatically requires such an approach. Fortunately, techniques of clinical and psychosocial measurement have improved during the past quarter of a century and there is now beginning to be a literature on which a new generation of medical and social scientists can build.

The accumulation of knowledge

Because evaluative research is conceptually and technically more difficult to carry out, and because projects take a long time and require much teamwork, compared with research in more restricted scientific fields, it is particularly important to remember that the process of acquiring knowledge is not in principle different. Knowledge takes longer to accumulate; that is all. But that means that it is all the more important to try to make studies as comparable as possible, by specifying clear aims, describing the sampling procedure in detail, using standard methods of measurement where possible and drawing attention to aspects of the results that may not be replicable in other areas.

It is also particularly important to spell out, within the limits of generalisation of the study, what the policy implications are. The more cautious scientists, who are aware of the deficiencies in their research, are sometimes reluctant - having spelled out its limitations - to make any positive statement that an administrator can understand and use. This is certainly better than making claims that cannot be justified but it is not the way to promote the creative relationship between research and planning that is needed if services are to develop in a rational way.

EVALUATING ALTERNATIVES TO THE MENTAL HOSPITAL

The data presented in Table 1 indicate the recent trends in bed-occupancy for the whole of England. Those in Table 2 use English figures as an estimate of long-stay (over 1 year) bed numbers but local Case-Register data from Camberwell in south-east London (Wing and Hailey, 1972) to estimate the numbers of people in other forms of hospital and non-hospital residential or

day accommodation who have also been in contact with some form of community psychiatric service for more than a year. This 'long-term' group totals 256 per 100,000; about three-quarters of the peak in-patient rate in 1954.

TABLE 2
Estimated numbers of people in residential or day care per 100,000 population of England

Service	Rate in long-term contact (Unduplicated)	
In-patients		
5 years and over, England, 1978	75	
1-5 years, England, 1978	39	
less than 1 year, Camberwell	38	
Day hospitals, Camberwell	32	
Day centres and workshops, Camberwell	52	
Non-hospital residential units, Camberwell	20	(37*)
Total	256	

Notes:
Long-stay in-patients, England, 31 December, 1978. Remaining figures, Camberwell. Patients and clients in day or residential care on a census day, or who had been in contact with some service (including out-patient clinics) for at least one year. The figures are given unduplicated, in the order shown, and can therefore be summed.

(*The figure in brackets gives the absolute rate for people in non-hospital residential care, many of whom were also attending day units).

It is convenient to use, for purpose of exposition, a crude classification into 'old' long-stay in-patients (i.e. accumulated during the custodial era), 'new' long-stay in-patients (i.e. recently accumulated, in spite of all attempts to prevent this) and 'other' (i.e. nearly all the time spent outside hospital).

The 'old' long-stay

Statistics show that the 'old' long-stay group in UK hospitals is still declining steadily, mostly by death. The people concerned are mostly elderly, with no contacts outside hospital and no desire to leave. This was not always the case.

Studies carried out during the 1950s and 1960s showed that many such people could be rehabilitated and resetled outside hospital. Poverty of the social environment had amplified the

'negative' disabilities of schizophrenia but this extra disability could be reversed. In addition, the longer a patient had been in hospital, irrespective of the quality of the social environment, to less likely was any wish to leave. This gradually acquired dependence was at the heart of institutionalism (Wing and Brown, 1970) and it occurred in people who were not otherwise severely disabled. Again, rehabilitation was effective.

However, many people remained severely handicapped even when living in a socially rich environment and have survived to the present day. 'Rehabilitation' is not an appropriate concept applied to them.

The 'new' long-stay

Several 'small descriptive surveys', both local and national, have been carried out to assess the characteristics and needs of the 'new' long-stay group not suffering from dementia. In general, they are socially disadvantaged, middle-aged to elderly, with few social or vocational skills, no roots in the local community and a long history of contact with other forms of psychiatric service before they became 'long-stay'. About half have schizophrenia. Many have short-cycle manic-depressive conditions. Many have relapsed on frequent occasions after having been discharged from hospital to less dependent forms of care. Many are multiply disabled - with physical and sensorial handicaps, brain damage or mental retardation as well as a psychiatric condition. Most have quickly, rather than slowly, become dependent on the institution.

Patients with such problems should not be living in a ward in a district general hospital. It is entirely the wrong setting for them. Modern concepts of care require that they should live as close to 'the community' as possible. (See paper in plenary session PL37 for comment on the concept of 'community'.) This means living in a house with the front door opening on a public street and the back door on a sheltered space, with adequate supervision and facilities for occupation and recreation. Such a house need not look or feel institutional or be anything like a hospital ward.

Preliminary evaluative studies suggest that such a solution is feasible and is much preferred by patients, relatives and staff. If an associated group home, supervised from the hostel-ward, is provided with some patients who can progress further towards integration into the community. What is not yet clear, although further research is now being undertaken, is what the cost implications will be of caring for all 'new' long-stay patients in this way.

Community care outside hospital

Similar studies have been carried out in order to evaluate the other alternatives to hospital care; including crisis intervention systems, day hospitals, work centres, sheltered workshops, hostels, group homes, protected housing, and the provision of activities during the evening and at weekends when the danger of relapse is often greatest. A related service, not yet adequately available anywhere, is counselling in the art and practice of 'living with' disability. Patients and relatives are rarely given much help with this, although to be handicapped and at the same time to be expected to live a 'normal' life, produces stresses that non-handicapped people do not have to cope with and find it difficult to imagine.

Overlapping these studies are others concerned with the primary care system which, in the United Kingdom, provides an essential element of support for patients and families. General practitioners act as 'gatekeepers' to specialist services and their advocacy, as has recently been demonstrated for dementia, may make all the difference between receiving and not receiving the forms of help that are needed.

IMPLICATIONS FOR THE FUTURE

It is perhaps rather obvious that the final questions to be considered here are those of organisation and of cost. Evaluative research is beginning to indicate how the needs for treatment or care of patients who formerly would have lived in the large mental hospitals can be met in other ways. What has not yet been demonstrated is that existing management, organisational and planning authorities responsible for such a heterogeneous collection of units and agencies (once they have all been brought into existence) will be able to meet the constantly varying needs of individuals, over long periods of time and without substantial increases in cost.

The principles of the National Health Service of the UK are district responsibility, comprehensive service coverage and continuity of care. A reasonably high standard should be reached nationally, not just in a few demonstration areas. That is the administrative challenge. For clinical and social scientists the task is to provide a body of independent, reliable and replicable knowledge that service planners and administrators can use. We can claim that a beginning has been made during the past 25 years and that the foundations, at least, of evaluative research are firm.

REFERENCES

Bockoven, J.S. 1956, Moral treatment in American psychiatry. J. Nerv. Men. Dis., 124, 167-194 and 292-321.

Wing, J.K. (Ed) 1982, Long-term Community Care. Experience in a London Borough. Psychol. Med., Sup. No. 2. Cambridge: University Press.

Wing, J.K. and Brown, G.W. 1970, Institutionalism and Schizophrenia. London: Cambridge University Press.

Wing, J.K. and Hailey, A.M. (Eds) 1972, Evaluating a Community Psychiatric Service: The Camberwell Register, 1964-1971. London: Oxford University Press.

THE PLANNING AND EVALUATION OF MENTAL HEALTH SERVICES IN THE UNITED STATES

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Mental health services in the United States are delivered in a variety of settings by a variety of medical and nonmedical professionals to a wide range of patient groups. These settings have multiple funding sources, both public and private, and mental health care is delivered through the general medical system, specialty services and a range of nonmedical systems in an unplanned and uncoordinated manner.

The United States has good examples of two extremes. On the one hand, there is the public, state and county mental hospital and the Veterans Administration psychiatric hospital system with services that are closely planned, evaluated and one might think even "overregulated." On the other hand, there is a large private care system, funded by private health insurance fees and some public monies, with care delivered mostly through "the hidden hand" of the marketplace. There are increasing pressures in the U.S. to contain costs of both public and private medical care, to regulate the provision of private medical care differently so that more competitive forces would control the costs of such care. Within mental health, the competitive arena is marked by a profusion of settings for the delivery of psychiatric care, including for profit and nonprofit private psychiatric hospitals, public and private general hospital psychiatric inpatient units, community mental health centers, state hopsitals and clinics and private offices. There is also a large number of private practicing general physicians, psychiatrists, psychologists, clinical social workers, psychiatric nurses, marriage and family counselors, occupational therapists, pastoral counselors, etc. Many states in the United States have so-called "freedom of choice" legislation, which allows these licensed groups to compete in the fee-for-service private arena, and for some of these nonmedical groups, especially

psychologists, to receive health insurance reimbursement.

ECONOMIC ISSUES

As is true in many parts of the world, the control of ever increasing health care expenditures is a major preoccupation in the United States. The aging of the population, increased costs and sophistication of medical technology, and the expectation of the people in receiving the best and latest of medical care has led to a problem for both the public and the private payor and for the society as a whole. In 1965, the year of Medicare and Medicaid legislation, total health expenditures of almost $39 billion represented 6 percent of the gross national product (GNP). By 1981, total health expenditures were $287 billion or 9.8 percent of the GNP. It is estimated that for 1982 this will expand to 10.4 percent of the GNP. By 1981, the average person in the U.S. was using twice as much medical care as in 1965, and the country as a whole was allocating 56 percent more of its resources to the production of medical care. A shift from 1965 to the present is the increasing role the federal government has played in the payment burden, jumping from 11.3 percent in 1965 to 30 percent in 1981. Private, third party insurance has remained essentially stable as a source of financing from 1965 to 1982, ranging from 25 to 28 percent of total costs.

Psychiatric costs have increased dramatically. In 1955, direct treatment costs were estimated to be $1.2 billion or 6 percent of all health expenditures. By 1977, the total expenditures on mental care had risen to $19.6 billion or 12 percent of all expenditures. The number of professionals delivering mental health services increased during this time period, encouraged by the availability of federal training grants and an expanding market economy for private care. Psychiatrists increased 183 percent, psychologists almost 300 percent and social workers 325 percent. Many of these professionals found initial employment in the expanding federally initiated community mental health centers program but moved to the private sector where the availability of private health insurance monies, especially for acute inpatient care in general hospitals and outpatient care, became more readily available.

The source of funds for mental care remains in the U.S largely a public burden with 25 percent of all funds deriving from the federal treasuries (mostly Medicare and Medicaid, the Veterans Administration, and public insurance programs for the military and federal employees) and 28 percent from state government, the traditional source of support for the poor, chronically mentally ill in the United States. Private insurance monies represent approximately 12 percent of the mental dollar.

Significant policy shifts have occurred at various levels in the public and private arenas to attempt to control these costs. The

first represents an effort to reduce utilization by making consumers more price conscious at the time of care or at the time when they purchase private health insurance. Medicare and private insurance programs are cutting back what is called "first dollar" coverage by adding deductibles and copayments, that is out-of-pocket payments, from patients at the time of the receipt of care. It has been found through empirical studies that utilization of services decreased dramatically if you require patients to pay for care rather than having a third party pick up the bill. It also has been found that if you ask insurance companies to compete in terms of premiums this also leads to certain efficiencies in coverage. A current proposal before the U.S. Congress would change the preferential tax status of health insurance premiums so that employees in major industry would become more conscious of the benefits provided by these premiums since these so-called fringe benefits would now become taxable income. The second method of controlling costs would make providers more cost conscious through a variety of systems of prospective payment. The most noteworthy experiment is the Diagnosis Related Groupings (DRGs) to be implemented for the Medicare program beginning in the fall of 1983. This system would provide for a prospective payment based on 467 diagnostic groupings (the discharge diagnosis) and would provide hospitals with these payments in full. If the hospital could treat these patients for less money than the DRG amount, they get to keep the difference in payment. If patients remain longer in the hospital than the prospective payment, hospitals have to bear the losses. It is expected that this new system of payment will eventually revolutionize the delivery of hospital care and create incentives for efficiency. Psychiatric diagnoses are included in this methodology but will be applied to patients admitted to the medical and surgical beds in general hospitals. Private or public psychiatric hospitals and psychiatric units in general hospitals are initially exempt from this approach. The nine psychiatric DRGs are based on ICD-9-CM, and it is hoped that a two year study would provide for a better diagnostic grouping, perhaps utilizing DSM-III, and more experience on the use of propsective payment for patients with psychiatric diagnoses. The DRG system represents a major effort on the part of government to regulate the private sector. It is a complex system, and it is unclear at the present time whether it indeed will achieve the goal of efficiency. If it does not, these regulatory changes might accelerate, and the reintroduction of national health insurance proposals could become a major factor in U.S. health policy in the near future.

In the mental health arena, state government remains an important source of support for major psychiatric programs. There has been an effort in several states to homogenize public and private dollars by requiring private health insurance monies for publically supported services in order to defray the costs of tax supported programs. Despite these efforts, the most significant planning and evaluation activity in the United States occurs in relation to the public health burden, that is for the long-term, chronic mental

patient. This group consists mostly of chronic schizophrenic or chronic alcoholic indigent persons who are the responsibility of the public treasury, both health and social welfare monies. One study estimated that there are now 1.7 million persons in the United States who suffer the disabling consequences of severe psychiatric illness which is likely to persist over a prolonged period of time. Of this population, approximately 900,000 are institutionalized in a variety of settings, mostly nursing homes, with another 800,000 living in a variety of community settings.[1]

CONCLUSIONS

The planning, regulation, evaluation of mental health programs in the United States is a response to the shifting nature of the economy as well as the treatment technologies available to care for people with long-term disabilities. Conflicting values of efficiency, accountability and access to needed care are played out in a variety of settings with a mixed track record of success. The dimensions of the problem of the poor, chronic mental patient in the United States are considerable and overshadow the resources that even a wealthy country like the United States might be willing to make available. The challenge today belongs to the private sector and government and to the profession of psychiatry in providing the leadership necessary to deal with the consequences of deinstitutionalization, the large numbers of homeless individuals in many of our cities and towns and the need to develop a responsive public policy to the balance of health and social welfare goals into the 1990s. As our population continues to age and the numbers of chronically ill individuals grow, psychiatry will have to establish a major leadership role for itself within the general health care system as well as the specialty mental health system. Planning and evaluation are key elements for understanding and for action in this endeavor.

REFERENCE

1 Department of Health and Human Services Steering Committee on the Chronically Mentally Ill, "Toward a National Plan for the Chronically Mentally Ill," DHHS Publication No. (ADM) 81-1077, December, 1980.

PLANNING AND EVALUATION OF MENTAL HEALTH SERVICES IN ITALY *

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Since the end of World War II, there has been a widespread opinion that it would be better to transfer the functions of mental hospitals to psychiatric units in general hospitals and to local non residential or semi-residential services. Many efforts have been carried out toward this goal, but no legislator had ever considered the possibility of prohibiting admissions to the traditional mental hospital. Nevertheless, in Italy this prohibition has been operating since 1978; for this reason, the ongoing organization of mental health services has been a source of great concern among politicians and research workers of many countries. The present report tries to describe some characteristics of the new organization, to provide some local trends based on empirical work and to discuss some preliminary issues for future planning and further research.

ORGANIZATIONAL ASPECTS

The new organization of the psychiatric care system was inserted into an ongoing process which started many years before and has produced a decline of patients resident in the large mental hospital. During the seventies, sporadic efforts toward comprehensive community-

*Supported in part by a grant (n. 82.02328.56) from the Consiglio Nazionale delle Ricerche

oriented mental health services were carried out in some zones; positive results, more or less enthusiastically acclaimed, were not always solidly grounded in empirical facts. In May, 1978, a new law was enacted. The essential features of the reform are: (i) since the date of the new act no "first ever" has been admitted to a mental hospital as inpatient; since July, 1980, in our catchment area, and in many other regions of the country, readmissions have also been prohibited; (ii) all residential treatments, both compulsory and voluntary, have been undertaken in small psychiatric wards attached to general hospitals; the units have been established with an approximative ratio of 0.15 beds per 1,000 population; (iii) it has been suggested that the greater part of long and short-term care should be assigned to outpatient departments, and local health authorities have been invited to implement the resources for non residential services.

At present, the closing of Italian mental hospitals means: (i) the construction of new large mental hospitals is prohibited; (ii) although new admissions to mental hospitals are not allowed, some people (mostly long-stay patients suffering from functional psychoses) continue to live in the large traditional hospitals; (iii) there are psychiatric wards attached to general hospitals which deliver short-term residential treatments. Other relevant characteristics of the Italian care system are: (i) a marked reduction in bed numbers for residential treatments, especially for those patients needing more than 2-3 months of stay; (ii) a shortage or, at least very few alternative settings for long-term care; (iii) a profound difference among regions and provinces, especially between North and South, as to the phasing of the deinstitutionalization programme and the implementation of the new law.

In more recent years, some evaluative work on the effects of the new law has been carried out, even though in some instances a short tradition in the field of epidemiological research has made it difficult to provide firm conclusions. However, some results seem consistent[1,2] : the reduction of compulsory admissions, an easier access to outpatient departments, and more care responsibility for professionals other than psychiatrists. In the meantime, five or more projects for modifying the Italian law have been proposed[3] by parties, unions and psychiatric associations. What will be the eventual developtment of the organization of psychiatric services is guesswork. At present, it seems more useful to provide some trends on the basis of empirical data, tentative and parochial though they may be.

UTILIZATION OF SERVICES

Since 1975, a psychiatric case register - modelled after the case register in London[4,5] - was set up in a health area near Pavia in Lombardia, a region of northern Italy[6,7,8]. Subsequently, some colleagues (trained by the Mental Hygiene Unit of the University of Pavia) set up case register procedures in three health areas of other regions of northern Italy, and comparisons of statistics were made[9,10,11]. At present, some information concerning the utilization of mental health services from a total population of about 300,000 inhabitants (0.5 per cent of total Italian population) may be provided. Some socio-demographic characteristics of the health areas are summerized in Table 1. Lomest is a medium-sized town in Lombardia; Albenga in Liguria and Novi in Piemonte are areas comprising a small town (less than 20,000 inhabitants) and many small rural villages; Sestri is a district of a large town (Genova) in Liguria. Obviously, agricultural workers are about 20-25 per cent in Albenga and Novi, and not represented in the larger towns. The only major difference from national figures is a higher percentage of economically active population. The mental hospital of each area lies outside its respective zone; the general hospital psychiatric unit is located within the area itself in Sestri and Novi, but about 40 miles away from Lomest and Albenga. The outpatient service for Lomest has been operating since 1975, and since 1979-80 for the other areas.

Table 1. Socio-demographic characteristics of 4 areas (1971 census)

	LOMEST	ALBENGA	NOVI	SESTRI
Total population	80838	52548	77298	86187
Inhabitants / Km^2	486	174	105	4100
Males / Females	0.93	0.96	0.94	0.94
% Aged 0 - 14	20	18	17	19
% Aged 65 or more	13	16	18	14
% Economically active (aged 15 or more)	42	47	56	43
Occupation				
% Agriculture	2	24	18	1
% Manufactoring	67	26	50	55
% Trade and services	31	50	32	44

Table 2. Lomest, 1-year prevalence (1976-81) for various types of contact : rates per 1000 population aged 15 +

Type of contact	1976	1978	1979	1980	1981
A: inpatient on 31 Dec. of previous year	0.85	0.87	0.76	0.73	0.68
B: not A, but admitted during the year	1.55	0.76	1.09	0.87	0.81
C: not A and B, but outpatient on 31 Dec. of previous year	1.83	1.63	1.18	2.25	2.14
D: not A, B and C, but outpatient contact during the year	2.92	4.76	4.64	4.38	4.36
Total	7.15	8.01	7.67	8.18	7.99

Table 2 shows the distribution of various types of care represented in Lomest 1-year prevalence rates: the overall rates increased untill 1978, but after the law they seemed to level off at a rate of 8 per thousand population aged 15 and over. According to different patterns of contact, the most relevant features are: numbers of people in hospital on census day are fairly stable; numbers of patients admitted to the hospital are decreasing; treated outpatient rates are about four times higher than inpatient rates. What may be tentatively inferred from these data ?

Since the surviving old long-stay inpatients are not particularly elderly, it might be assumed that they will remain a heavy load on the mental health care system for a long time. Their numbers cannot increase because the build-up of new long-stay inpatients is prohibited: however, no administrative decision can eliminate those mentally ill who will continue to become chronic patients needing long-term care in future years. These patients will probably accumulate elsewhere.

Admissions to general hospital psychiatric units seem to decrease year after year, and this trend may be the obvious effect of the marked reduction of bed numbers. We do not think that a ratio of about 0.15 beds per thousand population is realistic to satisfy the residential treatment needs of mentally ill, unless a very extended network of out-care has been previously set up. At present, this is not the case in Italy; the danger is that some patients fall out of

care or the waiting list of other wards grows longer.

At the present time, treated outpatients seem to be composed of two large categories: people who become patients in prolonged contact and those disappearing after few visits. The former are for the most part previously disharged psychotics and they do not differ significantly from the new long-stay inpatients who accumulated before the 1978 act; the latter seem to be essentially people suffering from minor psychiatric disorders. The problem is that the former represent only about 20 per cent of total 1-year prevalence rates, but account for about 80 per cent of total outpatient service activities. If this trend remains consistent in replicated evaluative studies, the danger is that non residential psychiatric facilities will be restricted only to the specific function of care-givers for well-known patients suffering from the most seriously impairing conditions of mental illness.

Are there relevant differences among data from various areas ? Figure 1 provides the distribution of contacts in four areas of northern Italy with a total population of about 300,000 inhabitants. There are similarities and differences, but the former seem to

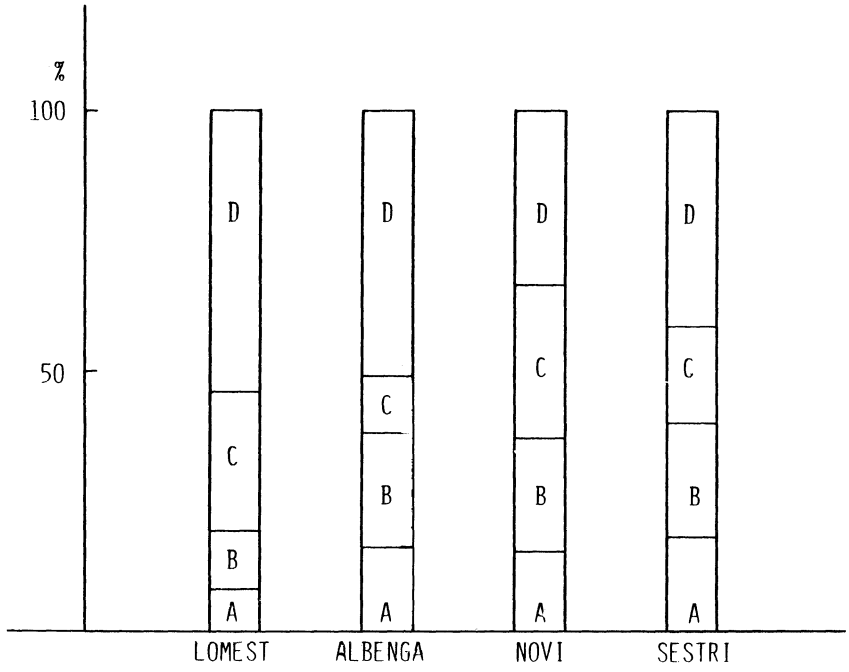

Fig. 1. Total patient population (1981) in 4 areas. By types of contact with in and outpatient facilities: percentage (A, B, C, D as in Table 2)

Table 3. "New on the register" patients (1980) in 4 areas. By diagnosis : percentage

Diagnosis	Lomest	Albenga	Novi	Sestri
Schizophrenia	8	6	7	5
Affective psychoses	12	17	12	13
Dementias and other organic conditions	2	4	1	3
Neuroses	64	65	65	62
Alcohol dependence	2	4	/	9
Personality disorders	2	4	4	7
All other conditions	10	/	11	/
Total number	142	47	153	141

outnumber the latter. If such were the case, it might be assumed that previous suggestions were more solidly grounded in empirical facts; however, the trends are not homogeneous everywhere. It seems that average estimates are more confusing than clarifying, as different levels of factors are probably contributing to various distributions among areas. Some of the factors involved may be: a different impact of the deinstitutionalization programme, socio-demographic characteristics of the zones, the distance from residential settings, and the more or less community-oriented policy of the services.

Do the differences among areas depend on different inception rates of mental illness or are they produced by various organizational aspects of the services? Table 3 shows the distribution of "new on the register" patients in the four areas by diagnostic categories[12]; the "new on the register" figure represents a purely operational measure, but it should approximate the number of new patients reported to the community psychiatric services. Percentages are very similar; it seems that the area differences in various contact rates must be ascribed to factors other than different distributions of particular diagnostic categories. In any case, further research is needed.

FUTURE PERSPECTIVES

In general, the last sentence is certainly correct and opportune, but in a sense it is also obvious and relieves scientists of the responsibility of providing planners with clear-cut elements with which

to work. Wing[5] stated that each planner must be a bit of an evaluator and each evaluator must be a bit of a planner. We are doubtful that the first part of the suggestion can be easily achieved, but efforts could be made with regard to the second part.

In the near future, resources - where available - will probably be invested in residential structures for medium-term care as alternatives to the old mental hospital. It might be suggested that even though organizational aspects are relevant, they are not the only issue to be considered. Adequate patient assessment, evaluation of clinical and social outcomes and specific care-fitting patterns (not designed for unspecified categories of mental illness but for the needs of each individual patient) must become the ultimate goals of each new facility. Obviously, health planners must accept constant monitoring and evaluative research as essential features of service innovations, but administrators continue to be elusive on this subject, at least in our country.

If available data are consistent, they seem to indicate that the treatment of minor psychiatric disorders is the Cinderella of public mental health service activities. In fact, if neurotic patients need only drugs, then family doctors are sufficient to prescribe and follow-up; however, if they need more sophisticated treatments, then public clinics do not seem an appropriate setting in which to care for them. The danger is the developtment of a system of public services for the more severely mentally ill and of many private practices for people suffering from minor psychiatric disorders. As a consequence of this, it would be easy to predict a strict selection, essentially based on the socio-economic status of the patients. Devising patterns of care to cater for the needs of patients suffering from minor psychiatric disorders should become a more relevant concern of people involved in the public mental health system, at least in our country. There are serious difficulties, of course. Tentative suggestions might be discussed with regard to research policy; for instance, to support primarily projects based on continued work on non psychotic disorders, and those able to provide scientific conclusions and practical, transferable indications for the services.

The shortage of more precise, well-defined perspectives depends certainly on my own limits and probably on the need for more extended evaluative studies on the effects of the recent Italian psychiatric reform. However, a final remark seems opportune, in our opinion: few but hard data based on empirical work are more useful than personal opinions, no matter how sophisticated these may be.

REFERENCES

1. M. Tansella, G. Meneghelli, and O. Siciliani, Implementing a community psychiatric service in South Verona under the new Italian mental health act, Psychiat. Soc. Science 2:105 (1982)
2. R. Misiti, Future developtments in Italy, Presented at the E.S.F. workshop on "Needed areas of research on long-term treatment of functional psychoses", Bagnaia (Italy) 9th-11th May, 1983
3. F.C.R.S. sulla Devianza e l'Emarginazione, "Manicomiomania: testi delle proposte di legge sulla 180", Ed. Dedalo, Bari (1982)
4. L. Wing, C. Branley, A. M. Hailey, and J. K. Wing, Camberwell cumulative psychiatric case register, Part I. Aims and methods, Soc. Psychiatry 3:116 (1968)
5. J. K. Wing, and A. M. Hailey (eds), "Evaluating a community psychiatric service: the Camberwell Register, 1964-71", Nuffield Provincial Hospitals Trust, Oxford University Press, London (1972)
6. E. Torre, A. Marinoni, and G. Allegri, Lomest psychiatric case register: old and new long-stay patients, Soc. Psychiatry 17:125 (198
7. E. Torre, A. Marinoni, G. Allegri, A. Bosso, D. Ebbli, and M. Gorrini, Trends in admissions before and after an act abolishing mental hospitals: a survey in 3 areas of northern Italy, Comprehensive Psychiatry 23:227 (1982)
8. A. Marinoni, E. Torre, G. Allegri, and M. Comelli, Lomest psychiatric case register: the statistical context required for planning. Acta Psychiatr. Scand. 67:109 (1983)
9. E. Torre, D. Ebbli, A. Marinoni, G. Allegri, P. Ciancaglini, and C. Castelnovi, I registri dei casi psichiatrici di Lomest e dell'Albenganese: confronto di dati per la valutazione dei servizi, Riv. Sper. Freniatr. 107:62 (1983)
10. D. Ebbli and P. Bonizzoni, Prime valutazioni dei servizi psichiatrici di due aree sanitarie della regione Liguria:l'Albenganese e Genova I^, Formaz. Psichiatr. 3:129 (1983)
11. E. Torre, A. Marinoni, C. Girardengo, G. Scoglia, I. Oberti, and V. Demicheli, Uno studio comparativo dell'utenza dei servizi psichiatrici di due aree sanitarie: i registri di Lomest e del Novese, Formaz. Psichiatr. 3:95 (1983)
12. General Register Office, "A Glossary of Mental Disorders", H.M.S.O., London (1968)

CRISIS INTERVENTION AND EMERGENCY PSYCHIATRIC SERVICES IN EUROPE

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This is a report on a study undertaken by the two authors on behalf of the European Regional Office of the World Health Organization. About 6 years ago, the World Health Organization decided that special attention should be given to recent developments in the psychiatric services that deal with acute illness and emergencies. There is often an overlap with "crisis emergency" services, and one of the objects of the work was to examine this overlap so as to see if a style of work or set of techniques could be identified that has anything new to offer to those responsible for psychiatric services.

There is an extensive literature on "crisis theory" and "crisis intervention", coming largely from the United States of America during the 1960's. The whole subject is very extensive, so this study had to have limits. It was, therefore, confined to emergency units clearly identified as part of the psychiatric services, and preferably having an overnight stay facility (although this was often limited to only a very few days). Included in both parts of the study were psychiatric units who claimed to do emergency or crisis work without necessarily having any extra facilities and with no special label or title referring to crisis intervention.

The first part of the study was done in 1977 by one of the present authors (J.E. Cooper). A publication was produced in 1979 in the form of a WHO report "Crisis Admission Units and Emergency Psychiatric Services", report no. 11 in the "Public Health in Europe" series.

This gave detailed description of the setting and working methods of 15 units visited (in 7 countries) during March 1977. The centres visited are shown on the left side of table 1.

Table 1

Crisis intervention units and psychiatric emergency services visited during the project

1977		1983	
Amsterdam Groningen Utrecht	Holland	Reims Paris	France
		Barcelona	Spain
Linkoping Karolinska Hospital Nacka Project	Sweden	Trieste Roma Arezzo Perugia	Italy
Helsinki Services	Finland		
Barnes Unit, Oxford Maudsley Hospital Edinburgh Regional Poisoning Centre Royal Edinburgh Hospital Experimental Ward	U.K.	Budapest	Hungaria
		Athens	Greece
		Belgrade	Yugoslavia
Central Institute for Mental Health, Mannheim	FRG	Berlin West Munich	FRG
		Berlin East	GDR
Geneva Services	Switzerland	Zurich	Switzerland
Sofia Pleven	Bulgaria	Vienna	Austria

In the first part of the study, each centre was visited, usually for 2 days, and several members of the working staff were interviewed. An extensive check list and questionnaire was filled in by the investigator, covering methods and hours of work, catchment area covered, source of referrals, destination of discharges, and many other aspects of each unit. An account was then written of each unit, trying to give complete description of the workings of the unit. Particular attention was paid to the problems of organization and professional identity, with a view to examining the effectiveness of role-blurring or role-sharing.

Descriptions of this type form the bulk of this first report, together with a brief historical review of the theory and practice of crisis intervention.

The report concluded that there appeared to be a "crisis practice" that could be identified as a common element in many centres, and which was similar to that noted in the literature from the U.S.A. It was more difficult to find any agreement about an identifiable and useful body of "crisis theory", in spite of the comparatively enthusiastic literature.

"Crisis practice" had the following features:

(1) Frequent meetings of small multi-disciplinary teams, run on a democratic basis, often as frequent as two per day.

(2) Frequent interviews and contacts by individual team members with patients and their families between the team meetings: again, more than once a day was not uncommon.

(3) Rapid decision-making by a nominated key worker for each patient, but with the team sharing the responsibility of the decision as far as possible.

(4) A consequent sharing and blurring of professional roles.

(5) A rapid turn-over of patients, with little follow-up after an intense working period of often less than a week.

The publication was well-received by many workers in this type of service, and appeared to fill a need for information about the detailed workings of such services. Since then, the number of emergency and crisis services in Europe has continued to increase, and a number of units or services have appeared in countries which previously did not have them.

Because of the continuing interest and development, the WHO decided in 1981 to commission a further similar study. This also gave an opportunity to include more centres from French and German speaking countries.

Accordingly, Dr Heinz Katschnig is currently visiting a further selection of similar centres (see table 1 right side), using the same method of a personal visit plus the filling in of a check list and detailed questionnaire schedule. This adds a further 15 centres in 8 more countries, giving a total of 15 + 15 = 30 centres in 15 countries.

We are both aware that there are other centres in the countries visited, and in those not visited, that do the sort of work we have been studying, but a complete survey is obviously impracticable, unless a totally different scale of effort and resources becomes available.

We have covered a wide variety of centres, services and individuals, and must have gained a general view of what is going on in Europe in this field. It will be of great interest to see to what extent the findings of the first part of the study are confirmed by the second part. Dr Katschnig is still preparing the report on his visit. So it will be some time before details can be compared, but already it is clear that broadly speaking the same developments and practices are continuing.

We have time today to mention just a few of the more general points that have already emerged:

First, there is a wide (if not extraordinary) variety of emergency services. They vary from small, closely-knit multidisciplinary teams with a specific "crisis" label and identity, to individuals who are simply members of the ordinary psychiatric services taking their turn (often with no special enthusiasm or training) at being on the emergency duty rota for the day or night.

One major decision that has to be taken everywhere, is wether to specify individuals or teams as special emergency workers with an identity and premises, or whether to leave the ordinary psychiatric team to cope with emergency work within its overall program of work. There are still conflicts of opinion on this fundamental point, but it seems that the countries of Northern Europe (Scandinavia, U.K., Holland, and to some extent Germany) contain many specified crisis centres, whereas the countries of Middle and Southern Europe contain few who work on the basis of a specific crisis theory.

Separate from this issue is the question of providing a crisis service with or without a specific catchment area. In many countries there is now a trend towards sectorization of psychiatric services,

and perhaps a sector service should include a special crisis service. This will depend upon the resources available; the most luxurious level we have found was in the Nacka Project in Stockholm, where each of three sectors of 25.000 persons had a team of about 10 therapists - this is a level way above what most countries can afford.

We have both remarked independently upon one rather unexpected feature of the more highly specialized and "crisis labelled" units; this is that these self-identified crisis workers are rarely willing to leave their own premises to go out into the patient's homes. In contrast, many of the outwardly more orthodox psychiatric teams coping with emergency work without calling it 'crisis work', regard domiciliary visiting to see the family and the home circumstances as part of the ordinary assessment procedure. This is, in our opinion, a reflection of the slightly aggressive attitude found in some of the more theoretically inclined crisis workers, which leads them to be always questioning the patient about what are they going to do, what are they going to decide. This is appropriate only for certain types of patients at certain times, and so usually goes together with a fairly rigorous selection of only certain types of patients for the crisis service.

This problem of selection and filters is the last point we have time for. It is all-important, and determines the size and troublesomeness of the flow of patients through any emergency service. In turn, it is decided by the extent and nature of the medical, social and ordinary psychiatric services, into which a special emergency service has to be fitted.

If an emergency service has to take all cases at all times, including acute alcoholics, then it must have a distinct medical component. If alcoholics of all types, drug addicts, chronic schizophrenics and other refractory types are excluded, then a unit can relax into a less medical and more problem-solving approach, with very different results for the style and pace of work.

The final report will no doubt bring together these and other points, but it is doubtful wether it will attempt to give any positive advise or prescription for the design of emergency services. It is more likely to provide further detailed commentary and information which will allow those who are interested to decide which type of service to aim for, and what are the main problems they are likely to encounter in so doing.

REFERENCES

Cooper, J.E.: Crisis Admission Units and Emergency Psychiatric Services. Public Health in Europe 11. Regional Office for Europe, World Health Organization, Copenhagen 1979

EVALUATING THE IMPLEMENTATION OF COMMUNITY MENTAL HEALTH CARE

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With respect to the increasing number of beds and the overcrowding of mental hospitals in many countries in the middle of the century, attempts to avoid long stays in hospital became a major goal among reformers of the mental health care system. The attempt of reducing patient populations was based on a profound dissatisfaction with the conditions and effects of mental hospitals. As a result, several countries with very high bed rates showed a significant decline (HÄFNER and KLUG, 1982), whereas at the same time the number of admissions has continued to rise. In the beginning, the developments of community alternatives to inpatient treatment were prompted more by political and economic considerations than by any planned treatment strategies. Comprehensive services to the mentally ill in the community have been justified for a variety of reasons, ranging from the clinical-humanitarian to the fiscal-political. Although this broad array of rationales was useful initially, continuation must be justified in terms of benefits that they produce. Fiscal appropriations may be ultimately determined by political or other criteria, data about effectiveness of services are vital for continued funding.

What is the career of a long-term disabled psychiatric patient in an era of community treatment?

In connection with the stepwise implementation of a comprehensive community mental health service in Mannheim since 1969 (HÄFNER and KLUG, 1980,1982) we investigated the impact on the care provided for chronic schizophrenics with respect to beds in psychiatric hospitals, places in complementary services and utilization of services for outpatient care. Especially we wanted to know how much care has to be provided in the community for discharged schizophrenics who are no longer hospitalized for extended periods of time.

Our investigation was based on an analysis of utilization data of the cumulative psychiatric case register at the Central Institute

of mental health in Mannheim for the period 1973-1980 and on a cohort study among all inhabitants of Mannheim with the diagnosis of schizophrenia who had been admitted to mental hospitals during one year (1.10.77 - 30.9.78).

Results

When the number of beds for schizophrenic patients in Mannheim provided in hospitals and homes are combined, a slight increase of about 10% can be noted (see Fig.1.).
It results from a distinct increase of more than two-thirds in the number of patients institutionalized in complementary services and from a reduction of at least 30% in patients admitted to mental hospitals. This trend appears to be continuing.

The proportion of long-stay patients (over one year) among the total number of schizophrenics treated in psychiatric hospitals or homes has changed from 192 (84%) on 30th May 1973, to 170 (74%) on 15th December 1980.

Even under the conditions of an extensive community mental health service, a group of "new" long-stay patients (census day 30.May 1973), was found to accumulate.

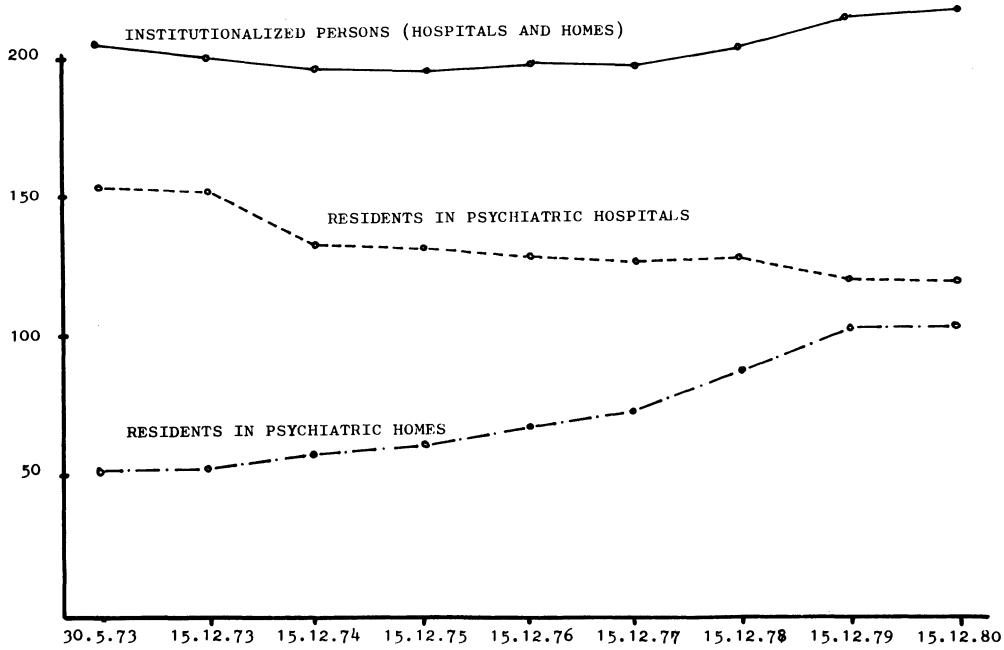

Fig.1. One-day Prevalence for Care in Psychiatric Hospitals and Homes Provided for Patients with Schizophrenia (ICD No.295) 1973 - 1980.

Compared to the old long-stay patients (census day 30.May 1973), whose numbers have continued to decline, even though more slowly, the new long-stay population has steadily accumulated (see Fig.2) reaching 65 on 31st December 1980.

The over-proportional rise in schizophrenics admitted in sheltered homes is quite revealing. Within a period of seven years, this population has increased from 30% to 60%. Three-quarters of those schizophrenics who became long-stay patients in 1980 were admitted to homes, whereas only one-quarter were admitted to the psychiatric hospital.
These changes reveal that the main burden of institutional care provided for schizophrenic patients has shifted from the mental hospital to the community and to the home. It seems that in the future under the conditions of an effective community mental health service, the majority of those schizophrenic patients needing long-term institutional care can live in sheltered homes or apartments in the community.

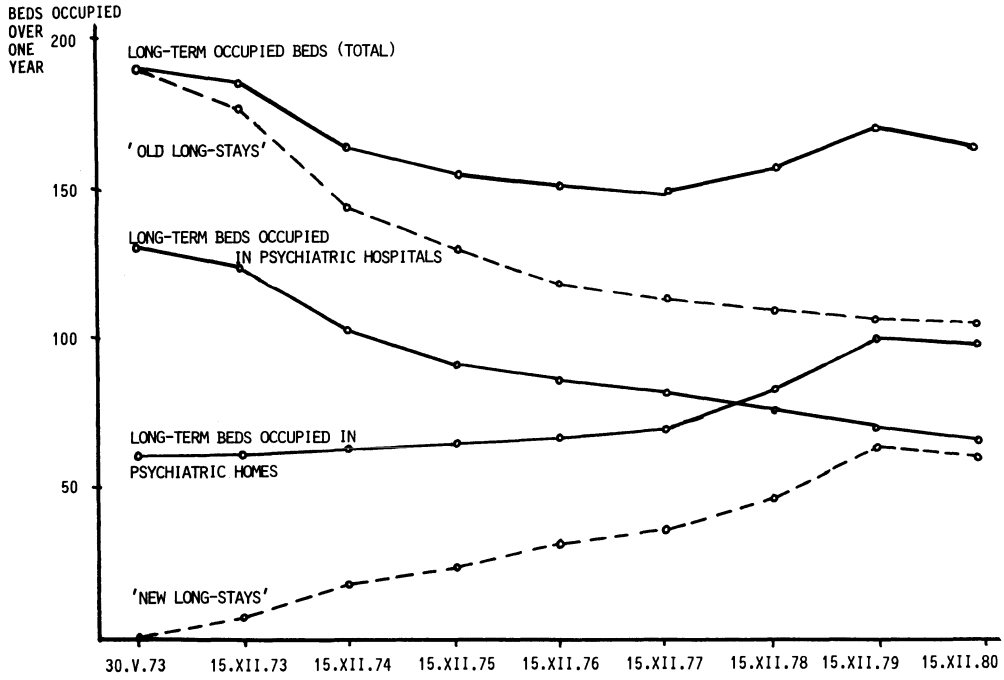

Fig.2. Trends in "Old" and "New" Long-Stay Population (Stay over 1 year) with Schizophrenia, 1973 - 1980.

In a structurally fragmented community mental health care system one has to pay special attention to continuity of care. As patients move between community and inpatient settings, opportunities arise for breakdown in communication. To meet patients' needs more effectively, coordination is necessary at the point when they pass from one agency to another.
In inquiring into the pattern of care in the extramural sector we observed the pattern of utilization by a group of patients prospectively over a period of 18 months. The cohort consisted of all Mannheim residents who were admitted to a psychiatric hospital between 1st October 1977 and 30th September 1978 with the diagnosis of schizophrenia (see Table 1).
After an average length of stay of 91 days, the patients were discharged from the hospital treatment.

Table 1. Rates of Intra-and Extramural Care

Institution	(patients)	Average rate p.100 patients and year *
Psychiatric hospital	148	9 270 days
Day-/night hospital	6	284 days
Sheltered homes	38	4 700 days
Sheltered workshops	36	2 560 days
Psychiatric out-patient department	136	485 contacts
Psychiatrists in free practice		915 contacts
Other physicians		460 contacts
Patient's clubs and miscellaneous	67	245 contacts

*) The calculation of the rates is based on a total of 148 patients. 38 Patients out of 148 lived in half-way houses or sheltered homes most of the time after their discharge from hospital. For five of these patients this was the first admission to a home. For 36 members of this patient group, care was provided in one of the two sheltered

workshops located in Mannheim. They amount to 27% of a total of 126 patients who according to their own statements have remained unemployed. 136 of the schizophrenics discharged from hospital had been in contact with medical services. The majority of them (90%) had seen psychiatrists in practice or had contacted the outpatient department of the Central Institute of Mental Health. Three out of the remaining twelve patients could not be discharged during the period of observation; five lived in sheltered homes and were provided with care by a psychiatric consultant. Only four patients had not been seen by any physicians.
Attention should be paid to the fact that roughly 30% of the patients have changed their physician at least once in the 18-month period and thereby interrupted the continuity of medical aftercare. This high proportion seems to reflect the difficulties of schizophrenic patients in entering into trustful relations (TANTAM and KLERMAN, 1979).

The pattern of utilization over time can be seen as a dynamic process which is reflected by the transition between the various states of care. These dynamics can be illustrated by means of a flowchart shown in Fig.3.

Analysis of the patient stream shows the transitions for all 148 patients. At cross-sectional point 1, all 148 patients are still in hospital. Fourteen days later, at point 2, 12 patients have been discharged; 10 of them have contacted an aftercare service; 2 have not received any aftercare; 136 patients remain in hospital. From cross-sectional point 3 on, the changes become more complex. One first readmission to hospital has been made from the "aftercare" sector. Furthermore, one patient who so far has not received psychiatric treatment has changed over to the aftercare sector. Altogether, a distinct decrease can be observed in the inpatient sector, corresponding to a marked increase in the "aftercare" and "no aftercare" categories.
Do aftercare services provided in the community help discharged patient remain in the community? The answer would be useful to policy makers and program planners in the mental health field. More patients than ever are being discharged from hospitals to the community. While the number of patients in hospitals has decreased, admission and discharge rates have increased. Consequently, the new pattern for many patients is short-term hospitalization before return to the community. There is a shift of the main burden of care for chronic patients from the hospital to the complementary services, while the hospital is prepared to provide crisis intervention and emergency care.

In reality, extramural care in Mannheim is often not limited to the utilization of a single agency. Very frequently, patients contact several, in extreme cases up to five agencies at the same time. Most cases of multiple utilization consist of visits to a physician combined with stays in sheltered homes, attendance at a sheltered workshop or/and a patient's club. This is one consequence of the provi-

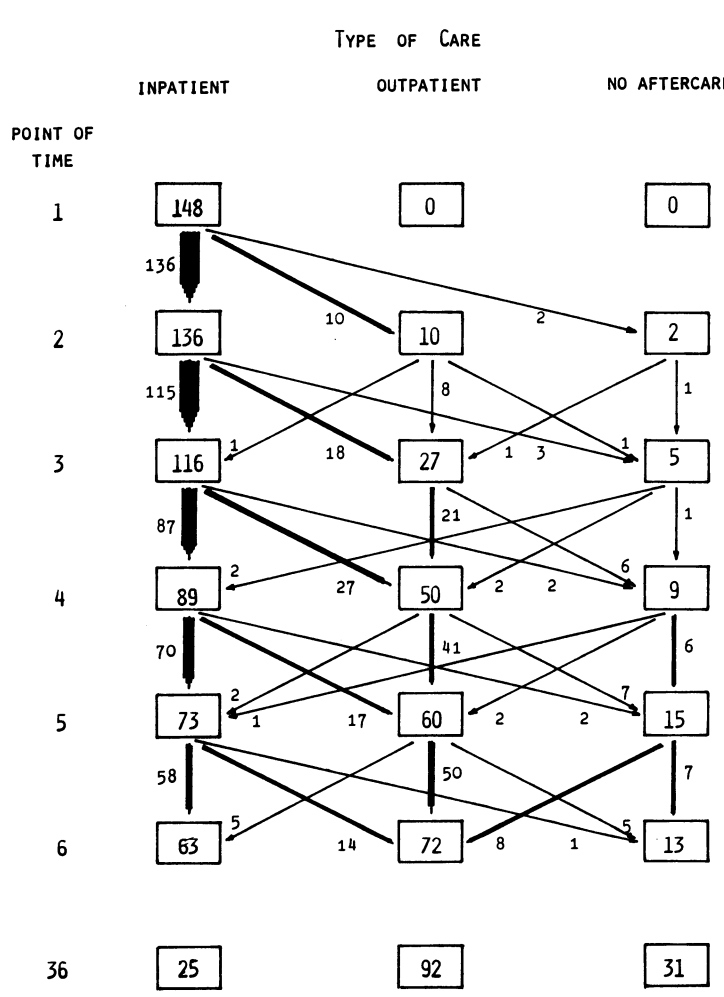

Fig. 3.

sion of a network of rehabilitation facilities for chronic schizo - phrenic patients in the community. The network provides various kinds of help, depending on the individual's needs: medical treatment, housing, occupation and social activities.

One essential aim of an extensive community care is to enable the mentally ill to live and participate in their normal surroundings as long as possible (BYERS et al., 1978). In fact, the dense network of extramural services provided in Mannheim seems to have this effect.

As shown in Fig.4, we have divided the cohort into three groups by intensity of utilization, which was operationalized by summing up all contacts of a patient with extramural services during his time outside hospital. On this basis, the whole sample was divided into three subsamples and the probability calculated for each that its mem-

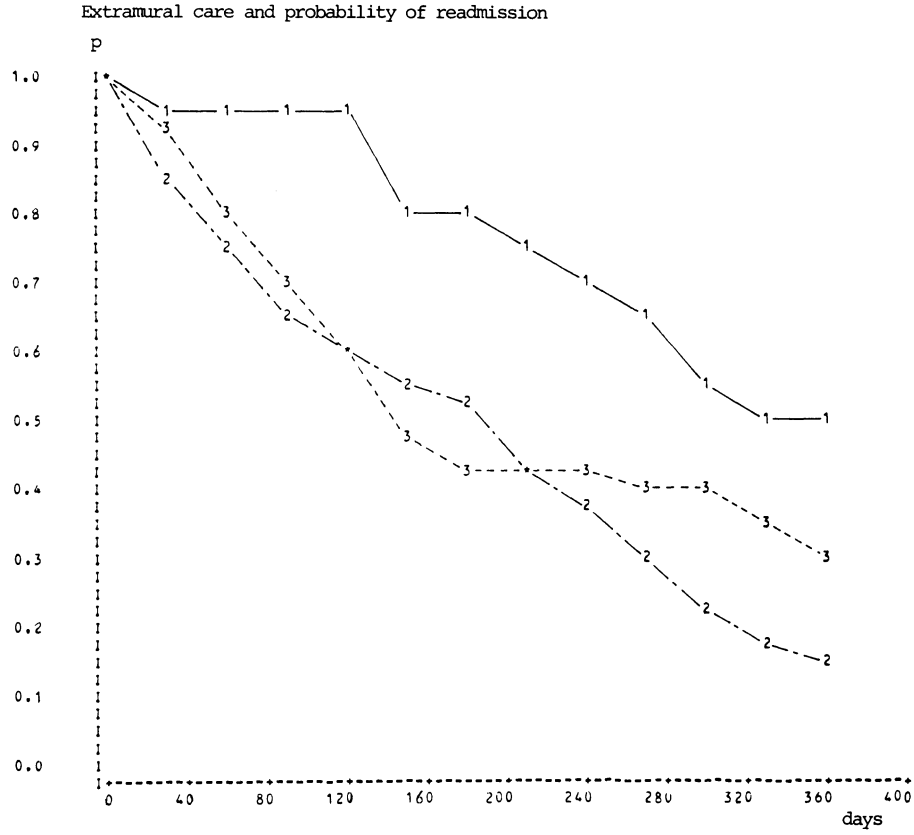

Fig. 4.

bers will not need hospitalization. The object of this analysis is to determine the interval between discharge from an inpatient service and readmission.

For the subgroup with the most extensive utilization of complementary services, the cumulative probability of not being readmitted to hospital within one year is 0.30. The probability for the subgroup with medium utilization, 0.14, is considerably lower. The subgroup with lowest utilization rates is not fully comparable, since it mainly consists of patients with a relatively short duration of schizophrenia and thereby with a favourable prognosis. We may conclude that an extensive utilization of extramural facilities reduces the probability of readmission to psychiatric hospital.
Aftercare for discharged hospital patients has become a salient issue as an increasing number of patients return to the community from hospitals. Community mental health care systems attempt to enhance, or at least maintain the patient's levels of functioning and to extend the length of their community stay.

Inevitably, the net of complementary services providing various kinds of help depending on the individual's needs, is extensive and rather costly. As regards its efficacy, it appears to have led to a distinct decrease in long-term hospital stay, especially among the so called "new" chronic cases. Our cohort study has also shown that the extensive utilization of the network of services by schizophrenic patients after being discharged from hospital definitely extends the interval until their next admission. At least to this extent, the effectiveness of this intensive extramural system of care is beyond question.

References

BYERS, E.S., COHEN, S., & HARSHBARGER, D. (1978): Impact of aftercare services on recidivism of mental hospital patients. Community Mental Health Journal 14, 26-34.

HÄFNER, H., & KLUG, J. (1980): First evaluation of the Mannheim Community mental health service. In Strömgren, E. (ed): Epidemiological research as a basis for the organization of extramural psychiatry. Acta psychiat. scand., Suppl.285, vol. 62, 68-78.

HÄFNER, H., and KLUG, J. (1982): The impact of an expanding community mental health service on patterns of bed usage: evaluation of a four-year period of implementation. Psychological Medicine 12, 177-190.

TANTAM, D., and KLERMAN, G. (1979): Patient transfer from one clinician to another and dropping-out of outpatient treatment. Social Psychiatry 14, 107-113.

INSTITUTIONAL CARE OF THE ELDERLY: A COMPARISON OF THE CITIES OF NEW YORK, LONDON AND MANNHEIM

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INTRODUCTION

Most developed countries can expect to have increasing numbers of elderly (over 65) in their population in the next decades. Optimal provision of care for the elderly, no longer capable of totally independent living, remains a major challenge. For many elderly, some form of institutional care will always be necessary. Each country has already developed a system of such care and a cross-national comparison of systems may illuminate possibilities of institutional care and the advantages and disadvantages of the alternatives.

The US-UK studies of the elderly (Mann, 1980) have focussed on the institutional provision for the elderly in the cities of New York and London (Gurland et al., 1979). The two city comparison has been extended to include the city of Mannheim, West Germany. A summary of the data from the three cities comparing the system of institutional care and the health status of a random sample of residents is presented here. A random sample of Care Staff was also interviewed in each city.

The two European cities have a somewhat larger proportion of elderly citizens but the age and sex distribution between the three cities appear similar. The number of institutional places per 100 elderly of the population and the proportion of places in

institutions providing a medico-nursing type of care versus residential care are shown in Table 1. It can be seen that despite having a smaller proportion of elderly amongst its population, New York provides a larger proportion of places than the European cities. Nursing Places:- New York: skilled nursing facilities. London: Psychiatric or Geriatric Hospital wards. Mannheim: Altenpflegelheim. Residential Places:- (personal day-to-day assistance, nursing and medical help not available in situ). New York: Health Related and Domiciliary Care facility. London: Residential Homes. Mannheim: Altenheim. (Special housing available in London and Mannheim is not included in this study).

Table 1 also compares the financing of institutional care in the three cities. In New York the majority are in private ownership, in London in public ownership and in Mannheim the majority are owned by voluntary organisations.

METHOD

A long-term care facility for this study was defined as a place where 4 or more unrelated elderly can live together for more than 6 months and take communal meals.

In New York and London a random sample (n = 24) of institutions was drawn from a list of all facilities meeting the above definition. Patients were selected at random to give a 0.5% sample of all in care. In Mannheim all institutions with more than 50 residents were selected for study, a 1/7 sample of females being studied. (To make a comparison, the males in the samples in London and New York have been omitted in this three city study.)

All selected residents were assessed by semi-structured interview (CARE. Gurland et al., 1977). Assessment methods have been described in full elsewhere (Gurland et al., 1979). In Mannheim an abbreviated version was used. Patient comparison is presented for (1) dementia (responses to the Organic Brain Syndrome Scale, 11 item, score $\geq$ 8 = severe dementia). (2) depression (abbreviated depression scale, 6 item, score $\geq$ 2 = depressive symptoms and (3) ADL Scale (0-41 point scale indicating impairment of activities of daily living). Depression items were only scored for subjects scoring $<$ 8 on the OBS scale. A random sample of Care Staff working in the institutions chosen for the resident study was also assessed using a semi-structured interview, The Nurses Aid Interview (Godlove et al., 1980).

Table 1

Some comparisons of the total elderly populations of New York, London and Mannheim. 1976

	New York	London	Mannheim
Total elderly population	940,000	1,031,000	85,000
Elderly as % of whole population	12.6	14.7	16.0
Of elderly population:			
% female	59	61	64
% male	41	39	36
% 65-74	63	64	64
% 75+	37	36	36
Long term care places per 100 elderly	4.7	4.6	3.9
Level of care			
% in nursing care	67	36	53
% in residential care	33	64	47
Ownership			
% proprietary facilities	54	7	19
% voluntary facilities	38	17	60
% public facilities	8	76	21

RESULTS

Residents

(1) 118 females (70% nursing care, 30% residential care, mean age 81.4) were assessed in New York. 119 females in London (40% nursing care, 60% residential care, mean age 82.7) and 139 females in Mannheim (52% nursing care, 48% residential care, mean age 80.4) made up the samples. London differed in that the residential care group were older than those in nursing care.

(2) 16% of New York and Mannheim samples and 21% of the London sample suffered from severe dementia (score $\geq$ 8 OBS)(N.S.). However, the former two cities had a much lower rate of dementia (3 and 6% respectively in residential care, in contrast to London - 17%).

(3) Mean ADL scores of all three samples were similar ($\simeq 9$). The sample in residential care in London was as disabled as those in nursing care, in contrast to the other two cities.

(4) Depression rate (score ≥ 2) was 54% in New York, 53% in Mannheim and 78% in London (London vs New York or Mannheim $P < .01$). Similar rates of depression were shown between residential and nursing care in London and Mannheim, but lower rates in residential care in New York.

Care Staff Assessment

London and New York employed similar people in this work (mean age 40, more than 50% foreign born); Mannheim differed (mean age 33, 10% foreign born). In each city, a significant minority of the samples ($\simeq$ 30%) said they preferred caring for confused residents and over 50% of the sample said they preferred caring for dependent residents. 53% of the London sample reported that they had had no training at all compared to 5% in New York and 14% in Mannheim. London staff reported carrying out significantly less activity, both nursing and day-to-day assistance in type, in their typical daily shift. More London and New York staff reported restrictions for residents in the institutions than Mannheim staff.

DISCUSSION

The systems of care against which this cross-national study has taken place are diverse. The three cities studied provide places for about 5% of their elderly population, but the balance between residential and nursing models care and between voluntary, public and private finance is quite different. The conclusions of this study, however, must be tentative because of methodological limitations. Though randomly drawn, the samples of residents were small and exclusively female. The diagnosis of the residents for depression, dementia and for their impairment of the capacity for daily living was based upon standard scale scores which, inevitably, have imperfect reliability and validity.

The findings may be summarised as follows:

1) In their long-term care institutions, the three cities house a similar group of old, disabled and demented residents.

2) London, providing most places in its system of care in residential homes, therefore houses a large proportion of these old and disabled people in a residential form of care. New York and Mannheim have clearly allocated the more disabled residents to nursing care.

3) Depression is common among the residents in institutional care in all three cities, but in London, in both forms of care, the prevalence of depression is significantly higher than in the other cities.

4) See Addendum

All these findings point somewhat critically at the London system. However, it should be remembered that residential care is cheaper than nursing care (by a factor of 2-5 in London). This economic factor must be taken into account in planning of care for an increasing population of elderly.

A cross-national study such as this is essentially descriptive and should lead to further investigations. One of these is of outcome. It cannot be assumed that expensive nursing care provided in a hospital-like atmosphere is the optimal model. It could be an advantage to maintain the personal atmosphere of the London residential homes. With the provision of more staff training these homes may then be better able to provide for its disabled population. Such questions can only be answered by outcome studies. One has been attempted comparing New York and London (MacDonald et al., 1981) but methodological difficulties in this study were considerable and further attempts are desirable.

Another area of research that might follow from this cross-national comparison is that investigating depression amongst this elderly population. Would the rates of depression be as different among the three cities, were the residents to be assessed at time of admission? If they were not and depression rates to diverge during the months after admission, what social, personal or treatment factors are associated with increasing or decreasing rates? Specific cross-national studies in this area would be rewarding.

ACKNOWLEDGEMENTS

At the Zentralinstitut fuer Seelische Gesundheit:
Michael Kelleher.
At the Institute of Psychiatry, London:
Rachel Jenkins, Caroline Godlove, Marshal Ross, Michael Shepherd.
At the Centre for Geriatrics and Gerontology, Faculty of Medicine, Columbia University and the New York State Office of Mental Health: John De Figeiredo, Margaret Shannon, Ruth Bennett, David Wilder, Harriet Wright, Eloise Killeffer, Paul Thompson, W. Edwards Deming.

This research was funded by grant from the Administration on Aging (AOA-90-A-1649).

REFERENCES

Godlove, C., Wright, H., and Dunn, G., 1980, Caring for old people in New York and London: the 'nurses aide' interviews. Journal of the Royal Society of Medicine, 73:713

Gurland, B., Cross, P., De Figeiredo, J. and Shannon, M. (New York); Mann, A.H. and Jenkins, R. (London), 1979, A cross-national comparison of the institutionalized elderly in the cities of New York and London,

Gurland, B.J., Kuriansky, J.B., Sharpe, L., Simon, R., Stiller, P. and Birkett, D.P., with Bennett, R., Copeland, J.R.M., Kelleher, M.J., Cowan, D.W., Dean, L., Deming, W.E., Holland, C., Shannon, M. and Wilder, D., 1977, The comprehensive assessment and referral evaluation. International Journal of Ageing and Human Development 8:9.

MacDonald, A.J.D., Mann, A.H., Jenkins, R., Richard, L., Godlove, C. and Rodwell, G., 1982, An attempt to determine the impact of four types of care upon the elderly in London by the study of matched groups. Psych. Med., 12:193.

Mann, A.H., 1980, The Anglo-American Geriatric Studies, Acta Psych. Scand., Supplement 285, Vol. 62.

Addendum (4)

4) A significant proportion of staff in each city report that they prefer to look after dependent or confused elderly. Care staff in London report that they receive less training and carry out less day to day help than staff of the other cities.

COST-EFFECTIVENESS ANALYSIS

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In a traditional cost-effectiveness analysis there is a single objective which is usually measured by a common physical unit (i.e. the number of breast cancers detected, number of chronic schizophrenics who return to full employment), and we want either to achieve a fixed level of objective at minimum cost, or as much objective as we can for a fixed cost. There is, therefore, some sort of outcome which is explicitly stated for each service or method of treatment, and the analysis will compare the cost of achieving the goal by various means. It is not easy to find examples of such analyses in psychiatry, since it is unusual to think of the effectiveness of treatment in such crude terms. Patients who have received a particular treatment cannot be usefully divided into 'still ill' and 'cured'; and indeed we may wish to examine the effects of a particular treatment on many different aspects of psychosocial adjustment. It is also sometimes necessary to evaluate services which do not reduce disability at all: for example, services for mentally handicapped children, or for severely demented old people. Fortunately, it is possible to modify cost-effectiveness analysis in such a way that useful conclusions about psychiatric services can still be drawn.

The basic strategy of such modified studies is to compare two alternative forms of treatment service as comprehensively as possible in terms of the quality of care provided and the effects which they have on their patients. No attempt should be made to express the value of these effects in monetary terms. An overall comparison is made of all the ways in which these two services compare with one another, and this is examined to see whether one service is clearly superior to the other, or whether no clear superiority emerges. The economic analysis is carried out

separately, and addresses itself to what each service costs. A service which is more expensive than another should be able to justify the increased cost in terms of the higher quality of the services provided. A cost effectiveness analysis provides us with a rough framework for effecting a comparison between expenditure on health care and the quality of the resulting service.

The essence of any evaluation is a comparison between two alternative forms of treatment service, or between a new form of service and an established form.

Stated in this general form, it is evident that cost effectiveness analysis covers a wide range of evaluative studies ranging from very simple comparisons on the one hand to highly complex controlled studies with prospective random assignment of patients on the other. For example, we might compare the quality of care available in two different kinds of childrens home in terms of quite simple indicators such as the quality of the buildings, the level of staffing in each and the training of the staff, the range of activities available for the children, the children's overall level of physical and psychological health, and the satisfaction of the children and their relatives with the care received. These qualitative differences between the homes would be offset against the cost of providing each service in terms of capital and revenue expenditure. Such a study could be carried out on a low budget by a trained research worker, and would not be especially time consuming. Although modest, such a study might enable firm conclusions to be drawn concerning a particular pattern of service.

At the other extreme are complex designs used to evaluate programmes for particular diseases which may have far-reaching economic consequences. If the economic analysis is extended to cover benefits as well as costs then these more complex comparisons are best described as "modified cost-benefit analysis", since a comprehensive comparison of two services in non-monetary terms is then considered together with a conventional cost-benefit analysis (Williams 1974; Glass & Goldberg 1977). An example of such a study would be the Manchester Schizophrenia Study (Goldberg & Jones 1980; Jones, Goldberg & Hughes 1980). This study compared the services offered by an area mental hospital and the psychiatric unit of a district general hospital by following two cohorts of first admission schizophrenics admitted to each service. The patients were compared in terms of the services used over the course of a year, and the investigators measured the clinical and social adjustment of the patients, and the effects that the patients' illnesses had on their families. The economic analysis was not confined merely to costs of the patients' psychiatric care, but included all cash flows caused by the patients' illnesses, first from the viewpoint of the rest of the community, and secondly from the viewpoint of the patients' families. It was possible to

bring all these financial effects together in the form of a single 'net effect' which represents the overall financial comparison between the services.

LEVELS OF COMPLEXITY OF THE ECONOMIC ANALYSIS

The simplest type of evaluation is confined to the direct psychiatric health costs of the treatment services. May's classic cost-effectiveness study which compared different treatments for acute schizophrenia merely considered the costs of various components of hospital care (May 1971); but Mancini and Burchell's comparison between mental hospital and the Maudsley hostel ward in the treatment of the new long-stay patient considered the costs per patient day in the two services, and also compares the capital costs. It emerged in the latter study that the hostel-ward was cheaper in terms of capital costs, but rather more expensive in terms of revenue costs: mainly because of the costs of paramedical supporting services and general services at this particular hostel. (The study is briefly referred to in Wing 1982; full details from the Economic Adviser's Office, DHSS, London).

Simple cost comparisons such as these are justifiable where the evaluation is being undertaken entirely from the viewpoint of the health providers, or where the patients receiving the service are not likely to either engage in open employment or to have adverse economic effects on other members of their families. If these conditions are not met, it is unwise to undertake such a simple economic analysis, since it is known that the indirect costs of psychiatric illness greatly exceed the direct costs.

An intermediate level of economic analysis is concerned with general costs, not merely of the psychiatric services, but also including general health costs, family doctor costs, local authority welfare services costs, social security payments and rent rebates, and travel costs. An example would be Mangen & Paykel's comparison between hospital out-patient services and community psychiatric nurses in the treatment of depression: here the total costs were 8 to 10 times higher than the psychiatric costs, and there was no overall difference between the services in economic terms. This study was superior in that it used prospective random assignment of patients to the two treatment services, but it was limited in that it did not measure economic benefits in the form of the patient's earnings. (Mangen & Paykel; 1983)

The most ambitious designs attempt to measure all the cash flows caused by illness from the standpoint of the patient and his family on the one hand, and from the rest of the community on the other. Thus, in addition to the above, one also records loss of earnings by family members who have had to stop work to look after the patient, extra earnings by family members obliged to work to help provide for

the patient, as well as the earnings of the patients themselves. Such detailed studies are time consuming and demanding, and can only be meaningful if the two groups of patients are exactly comparable in type of mental illness, chronicity of illness, and socioeconomic status. (It is obvious that if service "A" treats minor disorders in those with high income, it will be economically superior to service "B" that treats unemployed people with chronic psychoses and organic states; and that will be true however the two services are organised).

If we now apply these arguments to the evaluation of treatment services to those with long term functional psychoses, we see that in the case of a comparison between two essentially institutional forms of treatment the simplest form of economic analysis will be adequate, but if one service is community based it will be necessary to include data relating to earnings, since these are likely to make a substantial contribution to an overall economic evaluation.

LEVELS OF COMPLEXITY OF THE NON-MONETARY EVALUATION

The unthinking investigator has no clear hypothesis and measures everything in sight: symptoms of illness, disabilities and defects consequent upon illness, social adjustment of the patient - all these in both the patient and his living group - as well as characteristics of the treatment services themselves. If enough things are measured the hope is that any important effect will show up, and something will turn out to be significant. However, unless the investigator has no idea about the likely non-monetary benefits of a particular service, it is undoubtedly better to concentrate the evaluation on those aspects of outcome that are likely to be affected.

For example, if we are concerned with the benefits produced by a new antidepressant drug it will be sufficient to measure outcome with symptom scales focused on the phenomena of depressive illness, but if we are concerned with the effectiveness of an additional psychotherapeutic treatment of depression it will be necessary to include other measures of outcome that are relevant to the rationale of the new treatment. Thus we might include relapse rate and self esteem as outcome measures of the benefits produced by cognitive therapy for depression, and scales of satisfaction and social function in the assessment of interpersonal therapy (IPT) for depression, Scales measuring disabilities, defects and social adjustment are particularly relevant in the assessment of services for ambulant psychotic patients discharged into the community. In Wing's hostel ward comparison for example, where the patients in the comparison were all institutionalised, the evaluation included a patient's attitude scale and a time budget as well as a social adjustment scale, since it was anticipated that

the new service might produce advantages in these areas (Wing 1982).

THE IMPORTANCE OF A CLEARLY STATED AIM

Although it is usual to carry out comprehensive social and clinical assessments in two groups of comparable patients, the data produced by such assessments should be considered under two headings, the 'stated aims' of the evaluation and 'other effects'. First, did the new service achieve its intended aims? In order to measure this aspect of benefit we must assume that the service being evaluated has clearly stated aims, and that we have used rating scales which are relevant to these aims. The remainder of the data generated by the social and clinical assessments are used to ensure that any advantages of the experimental service are not at the cost of any other unanticipated disadvantages, and to test for any unpredicted advantages that the new service might have. In this part of the data analysis will be large numbers of analyses of which some will be significant by chance: in contrast any text in the former group which is significant can be interpreted more easily.

If the clinical status of a patient is expressed as a score on a symptom scale it is important that the scale is homogeneous in the sense of being a measure of a single dimension. It would therefore be reasonable to express outcome as a score on, say, the Beck Depression Inventory; but it would be unreasonable to express it as a 'total score' on an overall measure of psychopathology such as the PSE or the DIS. Where such comprehensive clinical assessments are used in evaluation, the only reasonable procedure would appear to be to compare the responses of the two groups taking the various ratings one at a time.

SOME METHODOLOGICAL PROBLEMS

It follows from what has been said that when we compare two services we are necessarily comparing two treatment packages. These are typically forms of service that are appropriate in the country concerned, but which offer a number of points of contrast with one another. Unfortunately if one service is clearly superior to the other, we still do not know which component or components were responsible for the difference between them. We can sometimes do a within-group analysis to see whether those patients who did particularly well with the superior service tended to use a particular component that was not available in the other service; but the results of such analyses will be suggestive rather than conclusive. The problem can only be solved by carrying out more comparisons in which we choose the services in such a way that the components are varied one at a time. This reminds us of the importance of replication in evaluation research: we need to know if our findings hold up across diagnoses, across social and

cultural settings, and for treatment packages which have many different combinations of characteristics. If the model for evaluation is too elaborate and time consuming, we will never obtain the number of evaluative studies that are necessary to obtain reliable results.

It must be remembered that a comparison between two services can only tell us which service is preferable: it cannot say whether there is not some other way of running a service that would be far more effective than either, or indeed whether it is worth having any service at all. Another problem is likely to arise if investigators choose large large numbers of non-monetary measures of the quality of service: the higher the number, the more likely are some of them to point in one direction, and some in another. The results can only be interpreted if one service is clearly superior to the other. If investigators clearly state the aim of a particular service, and devise a small number of outcome measures that are addressed to that aim, interpretation of results is likely to be straightforward.

REFERENCES

Glass, N.J. and Goldberg, D., 1977, Cost-benefit analysis and the evaluation of psychiatric services, Psychol. Med., 7: 701-707

Goldberg, D. and Jones, R., 1980, The costs and benefits of psychiatric care, reprinted from: "The Social Consequences of Psychiatric Illness", Robins, Clayton & Wing, ed., Publisher, Brunner/Mazel, Inc., New York, (1980)

Jones, R., Goldberg, D. and Hughes, 1980, A comparison of two different services treating schizophrenia: a cost-benefit approach, Psychol. Med., 10: 493-505

Mangen, S.P., Paykel, E.S., Griffith, J.H., Burchell, A.,and Mancini, P. 1983, Cost-effectiveness of community psychiatric nurse or out-patient psychiatric care of neurotic patients, Psychol. Med., 13: 407-417

May, P.R.A., 1971, Cost-efficiency of treatments for the schizophrenic patient, Amer. J. Psychiat., 127:10

Williams, A., 1974, The Cost benefit approach, Br. Med. Bull. 3: 30 252-256

Wing, J. and Wykes, J.,1982, Long-term community care: experience in a London Borough, Psychol. Med. Mono Suppl., 2: 59-97

EMERGING TRENDS IN RESEARCH AND SOCIAL PSYCHIATRY:

ACCOMPLISHMENTS AND FUTURE PROSPECTS

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In the past 20 years research efforts in social psychiatry have not only contributed to more appropriate and effective care for patients, but also has focused the research agenda more clearly. This paper will examine some important contributions, and efforts necessary to move forward in the coming years.

Understanding serious disorder, and the experience of patients with serious mental illness, requires a longitudinal perspective, but early efforts in social psychiatry were largely cross-sectional and, thus, deficient in portraying natural history and course of disorder under varying environmental conditions. We learned too little about what symptoms and diagnoses were transitory or stable, the long term effects of drugs and other interventions on symptoms and functioning, and the relationships between earlier and later disorder. Investigators have developed ingenious techniques for capturing the longitudinal character of mental disorder, and have carved out studies that have challenged many important preconceptions about the nature of the major disorders and their prognoses. Highly significant has been the realization that the schizophrenic disorders may not be as profoundly incapacitating as previously believed, and that many patients have a single episode of psychosis followed by complete recovery during the period of follow-up. In the discussion that follows, I plan to examine selectively samples of social psychiatric research that hold particular promise for future inquiry and for practice.

Family Environment and Schizophrenic Prognosis

In 1962 George Brown and his colleagues[1] at the Institute of Psychiatry in London reported on a group of schizophrenic men who

symptoms, and then seen at home with their relatives, two weeks following discharge. The investigators found that patients with relatives who showed high emotional involvement in the interview (based on assessment of expressed emotion, hostility, and dominance) deteriorated more frequently than patients living in a low emotional involvement environment. This observation has now been replicated in a variety of research settings.[2-4]

It appears that emotional involvement in the case of schizophrenic patients largely denotes negative emotions and criticisms, in contrast to positive feelings. While the effects on emotion are attenuated to a considerable degree when patients are maintained on neuroleptic medications, differences occur even in medicated patients. It appears that schizophrenics cannot tolerate high levels of stress, and that neuroleptics in part, blunt the effects of stress. Patients who have less face-to-face contact with relatives are also less likely to relapse in families with high expressed emotion.[5-6] Negative emotions of relatives is also tied to family tolerance and expectations, which in turn relates to the patient's retention outside the hospital.[7] These interactions are promising foci for continued inquiry.

Efforts have been made to apply these findings in a controlled study where family members of schizophrenics were taught about the condition, were instructed in problem solving techniques, and efforts were made to reduce family tensions.[8] Follow-up at 9 months found that patients in families receiving such interventions had a much lower rate of exacerbations than those in a control group receiving clinic-based individual supportive care. Only one patient in the intervention group (6 percent) was judged to have a relapse, in contrast to 8 (44 percent) in the control group. There is some indication that maintenance of medication regimens was superior in the intervention group requiring caution in interpretation, although adequate drug therapy does not necessarily prevent relapse. But this study, at the very least, demonstrates the significant possibilities of psycho-social interventions based on sound social research.

Study of Prognosis

Social epidemiology has emphasized a longitudinal perspective, the importance of studying the course of disease or disorder, and the differentiation of factors causing disorder from those affecting its course. In recent years a great deal of new information has become available on the course of schizophrenia, a disorder commonly viewed as chronic and progressive and having an inevitably negative outcome. Careful long term studies show this conception to be wrong, and the progressive decline often seen among schizophrenic patients in certain circumstances may have been a self-fulfilling prophesy.

In a remarkable clinical study, carried out over 27 years, Manfred Bleuler[7] studied the course of disorder among 208 patients in Zurich in varying cohorts over two decades. He describes the continuing adaptations among these patients who fluctuate between varying outcomes. Half to three-quarters of the schizophrenic patients studied achieve relatively stable outcomes that last for many years about ten or more years after onset. As many as one-third of patients achieved long term recoveries, and only 10-20 percent become severe chronic schizophrenics. The estimate of recovery is conservative, since it only includes patients reaching an end-state, and as Bleuler notes, prognosis of all schizophrenias combined is better. Moreover, in some patients, even after 40 years of psychosis, marked changes still occur. Long term studies carried out by Ciompi[8] in Lausanne and by Huber, Gross and Scheuttler[9] in Bonn confirm Bleuler's conclusions on the variable, and often positive course of the schizophrenias.

Bleuler did not find impressive differences explaining the varying outcomes of schizophrenia, but a variety of other studies are suggesting new leads. A good illustration is the International Pilot Study of Schizophrenia[10] which followed 1202 patients in 9 countries. At two-year follow-up, 27% of schizophrenics had a complete recovery after the initial episode, and 26% had several psychotic attacks with periods of complete or partial recovery. More striking was the large variation between developed and developing countries, with proportions of patients showing complete recovery, varying from 6 percent in Denmark to 58 percent in Nigeria. While patients in each country are not representative of the total population of schizophrenics in that nation, the findings are too striking to neglect--particularly in light of other studies.

Murphy and Raman[11], for example, carried out a 12-year follow-up survey of schizophrenic patients initially in a hospital in Mauritius. Although the researchers had no direct comparison group, they compared their results with data on schizophrenic patients in England, studied by George Brown, John Wing and their associates. They note that incidence rates for schizophrenia are comparable in England and Mauritius, but the proportion of patients symptom free and functioning normally was greater in Mauritius. Moreover, there were fewer relapses between discharge and follow-up than in England.

Waxler,[12] in a careful 5-year follow-up study of schizophrenics in Sri Lanka, found that 45 percent were symptom free as measured by the Psychiatric Status Schedule developed by Spitzer and his colleagues. Fifty percent were rated by the psychiatrist as having adjusted normally; 58 percent were seen by their families as having normal social performance and 42 percent had no impairment in the previous six months. Almost half of the

patients were said to have worked continuously over the previous five years, according to their families. Even allowing for errors in measurement, this is an impressive outcome, and at variance with Western conceptions of the course of schizophrenia. Waxler carefully examined possible artifacts in her results, and makes a persuasive case that her findings are indicative of important cultural differences.

The observed variations in the course of schizophrenia in underdeveloped and developed countries require careful study of factors that may possibly contribute to such important differences.[13-14] Waxler[12] believes that the explanation may be found in family structure, native treatment systems, common beliefs about madness, and common values, and suggests a social labeling model as the best approach to understanding these differences. I would suggest, in contrast, that more simple possibilities be first examined, consistent with findings already reasonably secure within the body of social psychiatric research.

In peasant societies, even the schizophrenic may be a useful economic actor, and can contribute to the family's livelihood in the home or in the fields. Not only is the patient aware of the importance of his or her labor, but there are strong mutual expectations within close kinship structures that encourage effort from the patient and normalization of bizarre thought and behavior from the family. The family is likely to be more supportive and encouraging, and less critical and complaining in such contexts. The ability of the patient to perform useful tasks, and the gratification of the family in avoiding the patient's economic dependence, may contribute to a relative climate of mutual satisfaction, in contrast to the situation in more competitive, complex societies characteristic of developed economies. In a sense, the culture may reinforce a positive climate, in contrast to the bitter criticism found in so many Western families in studies of schizophrenic remission.

We have learned as much as we are going to from gross cross-cultural comparisons and require studies that measure, in carefully matched contrasting societies, such variables as expectations, family tolerance, expressed emotion, stressors, social supports, available opportunities for meaningful employment, and social stigma.

As for treatment, Clausen, Pfeffer and Huffine,[13] in a follow-up study over 15-20 years of severely ill mental patients, traced the long term patterns of illness and help seeking. Relatively few of the married patients they followed over this long period became typical chronic cases, although many need repeated help. Half of the married men in the study, hospitalized with schizophrenia (and meeting DSM-III criteria) had no mental health

treatment of any kind subsequent to their initial hospitalization 15-20 years previously. Some had no serious symptoms over the intervening period, while others managed to get along despite persistent symptoms. This study is further support for the important observations of prognosis of schizophrenia, derived from the WHO collaborative study.[10]

Study of Risk Factors

The course of serious mental disorder is extraordinarily complex, but increasingly research is focusing specifically on important risk factors, measured more carefully and evaluated in the context of sophisticated multivariate designs. By way of example, I briefly review some current efforts to study stressful life events and social attachments.

There is a long history of concern with the role of stress in the occurrence of illness, but only more recently have investigators successfully measured the impact of events independent of subjective perceptions, and come to appreciate the importance of prospective prediction.[14-15] The Holmes-Rahe Social Readjustment Rating Scale[16] stimulated interest in this area of study, and more recently, there has been significant refinement of such measures.[15-17] There are fundamentally two approaches used. The first, like Holmes-Rahe, attempts to ascertain how many of a large number of life change events have occurred within a specified time period. Efforts are increasingly made to differentiate positive and negative life events, and events possibly affected by the person or independent of their motives and actions. The life changes may be weighted by the degree of social readjustment they require. The alternative method, developed by George Brown, involves interviewing the respondent in detail about each event. A rater, listening to the interview, then makes a contextual judgment. This rating is an assessment of the degree to which such an event, happening to this person in this particular context, would be disturbing and require readjustment.[18] The advantage of Brown's approach is that it better captures the meaning of the event in the context of the respondent's life, without confounding it with the respondent's subjective appraisals. Its disadvantage is the time necessary to make the rating, and the special instruction necessary for the rater. Careful comparison of these two methods, with comparable samples, would allow assessment of how results differ.

Stressful life events have been demonstrated to be important in the occurrence of depression, schizophrenia and a variety of medical disorders.[14] Depression appears primarily associated with loss events, while in other areas the relative role of negative and positive life change events remains confused. Much of this confusion is implicit in the gross characterization of complex

events in the Holmes-Rahe Scale, and adaptations of it,[19] which include negative, positive and ambiguous features.

The role of life change events takes on particular interest in association with other vulnerability or buffering factors.[20] Brown and Harris, in a study of depression in Camberwell, London, found that women experiencing significant stressors were protected from depression if they had an intimate spouse or lover, had an outside job, and were not overburdened with small children in the home. Those who faced the obverse conditions were likely to become depressed when faced with major life changes, and risk increased if they had lost their mother at an early age. Other studies similarly show the importance of buffering factors in the presence of stressful life events, which has directed increasing attention to such factors as coping skills and social support. While the former is only vaguely specified, and involves significant measurement problems, social support has become a major focus of research activity.

Numerous studies show that social support affects rates of illness, mortality and medical care utilization.[21-22] But the designation social support applies to a variety of measures that may, in fact, have little in common. The rubric may apply to the presence of a spouse or family member, an intimate other, or friends and neighbors; association with co-workers; participation in voluntary groups or religious activities; or social activity and participation in the community. In short, the concept has far too many referents. Despite the uncertainty of measurement, there is now a strong basis for focus on intimacy and networks of support as important predictors. It remains unclear, however, to what degree inadequate support and social relations are direct risk factors in pathology, in contrast to their roles in buffering the impact of adversity when it occurs.[23]

Efforts are just beginning to address the role of coping in the context of other biological and psycho-social influences. While measuring coping remains a formidable problem, attention is turning to such important questions as what protects individuals with high biological risk from disorder, as in the case of a person whose identical twin is schizophrenic, or the child of schizophrenic parents. We have as much to learn by carefully identifying protective factors as we do in isolating influences conducive to disorder.

Experimental Studies of Community Programs

Reference has already been made to a program of family management[6] to prevent exacerbations of schizophrenia, and more such demonstrations are necessary for developing effective community care. The field of mental disorder has not lacked innovative ideas. What has been least in evidence is the careful

evaluation of varying approaches to management and specification of successful interventions that can be transferred to new settings, once their value has been demonstrated.

The issue has at least two crucial aspects. First, a program of intervention that is replicable must be examined in a comprehensive way, so as to allow a fair and comprehensive evaluation of its benefits and costs. Second, the programmatic aspects must be readily transferable and not depend solely on the excitement of a new venture or charismatic leadership. The problem of transferability is illustrated by the rapid diffusion of drugs and new machine technologies, in contrast to the indifference or resistance to new social technologies. One major difference is that the costs of drugs and machine technologies are more easily transferred to consumers and third party payers, while complex social technologies that are intensive in the use of personnel, are more difficult to reimburse under predominant financial arrangements.

An especially interesting experiment in Wisconsin involved a training program in community living for chronic patients.[24-25] This study compared an educational coping model with a progressive hospital care unit. An unselected group of patients referred for admission to a mental hospital was randomly assigned to experimental and control groups. The control group received good hospital treatment, linked with a progressive program of community after-care services. The experimental group was assisted in developing an independent living situation in the community, given social support, and taught simple living skills such as budgeting, job seeking, and use of public transportation. Patients in both groups were evaluated at various intervals by independent researchers. The findings indicated that it was possible for patients who were highly impaired to be cared for almost exclusively in the community. Compared with control patients, patients in the experimental group made a more adequate community adjustment as measured by higher earnings from work, involvement in more social activities, more contact with friends, and more satisfaction with their life situation. Experimental patients at follow-up had fewer symptoms than the controls. This experiment illustrated that a logically organized and aggressive community program can effectively treat even highly impaired patients in the community, without hospitalization.

Such successful community programs are not without significant costs. A careful economic cost-benefit analysis of the above experiment, taking into account a wide range of hidden, as well as explicit costs, such as welfare payments and supervised residency costs, suggests that while such programs yield a net benefit, they are not less expensive in economic terms than more conventional approaches.[26] Moreover, there are social costs in maintaining patients in the community, as compared with hospital care during

the more acute phases of disorder, as reflected in law violations and assaultive behavior. The prevalence of such behavior was low, but not inconsequential. We shall require careful study and experimentation of the best mix of community care and short term and prudent use of hospital facilities. We also need a better grasp of the organizational, political, and financial arrangements necessary to allow these programs to develop and flourish.[27]

Long Term Impact of Intervention

There is almost universal awareness that the impact of drugs, surgery or any other physical intervention requires long term assessment for both beneficial and noxious effects. The importance of this has no better illustration than the growing evidence that the prevalence of tardive dyskinesia and other extra-pyramidal symptoms among patients maintained on neuroleptic medication, is greater than previously believed. Studies of social interventions, such as the long term Cambridge-Somerville experiment,[28] illustrate that well-meaning interventions may not only be ineffective, but also may have adverse consequences.[29]

Long term studies of social programs for chronic patients, whether in the hospital or the community, indicate that improvements in patient functioning and performance require continuing and persistent efforts. Wing and Brown,[30] in a study of three British mental hospitals in the period 1960 to 1968, found that with changes in these hospitals, patients benefited in the early years, but over time some of the progress achieved was lost. While there are alternative explanations for the slipback, the data reflect how difficult it is to maintain progress with chronically impaired patients over long periods of time. Comparable findings characterize community care. The progress achieved by the community care program described by Stein and Test[24] was lost once the program ended and patients returned to traditional care. A five year follow-up of the patients studied by Pasamanick and associates[31] also found that deterioration of patient functioning following the termination of the experiment.[32]

These studies all suggest, as do many others involving interventions to change health behaviors, that while short term improvements can be readily achieved, long term progress is a much more formidable goal for both patients and those responsible for their care. It is not clear to what extent initial progress is in part a result of the hope, enthusiasm and novelty associated with innovative efforts or new programs, or to what extent the loss of improvement reflects the inability of treatment staff to maintain their energies, interest and commitment with the same patients over time. Once we make the commitment to the need for longitudinal responsibility for chronic patients, identifying means to develop

and maintain efforts over time is a major task. This area of research has been substantially neglected.

Treatment Environments and Patient Adaptations

Patients live or are treated within a wide variety of community and institutional environments and make a life for themselves within a particular subculture. These may vary from a highly supervised and restrictive nursing home or board and care facilities, to a loose network of associations within the community within which patients share companionship, occasional meals and recreational activities.

Deinstitutionalization has resulted in relocation of many chronic patients to small decentralized facilities, varying greatly in physical and social characteristics and in psychological climate.[33, 34, 35] We know little about the impact of these environments and to what degree certain characteristics are helpful, or noxious. Those environments that lack active programs, and where patients spend large periods of time unoccupied or watching television, encourage loss of skills and diminished psychological and social functioning.[36] A great deal more needs to be learned, however, not only to regulate these facilities, but also to improve even the most basic care.

To summarize, efforts in social psychiatry have opened some new and exciting paths to better understanding the course of mental illness and how patient management can be improved. From a rather limited effort in the 1950s, it has expanded by clarifying concepts and definitions, by developing new and improved methodologies, and by facing complex longitudinal and multivariate issues. Social psychiatry has discarded much of the contentiousness so evident in the 1960s, asking more complex questions involving interactions between biological predispositions, psycho-social factors, and broader social and cultural influences. The agenda for needed research is large, and the research requirements often difficult and frustrating. The discussion here highlights but a few of the many possibilities that may contribute to improved patient management and more coherent mental health policies in the future.

References

1. Brown, G.W., Monck, E.M., Carstairs, G.M. and Wing, J.K., Influence of Family Life on the Course of Schizophrenic Illness. Brit J of Preven and Soc Med, 16:55-58 (1962).
2. Brown, G., Birley, J.L.T., and Wing, J.K., Influence of Family Life on the Course of Schizophrenic Disorders: A Replication. Brit J of Psych, 121:241-58 (1972).
3. Vaughn, C.E. and Leff, J.P., The Influence of Family and Social Factors on the Course of Psychiatric Illness: A

Comparison of Schizophrenic and Depressed Neurotic Patients. Brit J of Psych, 129:125-37 (1976).
4. Leff, J. Social and Psychological Causes of Acute Attack, in J. Wing (ed.) "Schizophrenia: Toward a New Synthesis," Grune and Stratton, New York, 139-165 (1978).
5. Greenley, J.R., The Psychiatric Patient's Family and Length of Hospitalization, J of Health and Soc Behav 13:25-37 (March 1972).
6. Falloon, I.H.R., et al., Family Management in the Prevention of Exacerbations of Schizophrenia: A Controlled Study. N Engl J Med, 306:1437-1440 (1982).
7. Bleuler, M. "The Schizophrenic Disorders: Long-Term Patient and Family Studies," (translated by S.M. Clemens) Yale University Press, (1978).
8. Ciompi, L., Natural History of Schizophrenia in the Long Term. Brit J of Psych, 136:413-420 (1980).
9. Huber, G., Gross, G., and Scheuttler, R., "Schizophrenia." Springer, Berlin (1979).
10. World Health Organization, "Schizophrenia: An International Follow-up Study," John Wiley, Geneva, New York (1979).
11. Murphy, H.B.M. and Raman, A.C., The Chronicity of Schizophrenia in Indigenous Tropical Peoples: Results of a Twelve-year Follow-up in Mauritius. Brit J of Psych, 118:489-497 (1971).
12. Waxler, N.E. Is Outcome for Schizophrenia Better in Non-Industrial Societies? The Case of Sri Lanka. J of Nerv and Men Dis, 167:144-158 (1979).
13. Clausen, J.A., Pfeffer, N.G. and Huffine, C.L., Help-Seeking in Severe Mental Illness. in D. Mechanic, (ed.), "Symptoms, Illness Behavior and Help-Seeking," Neale Watson, New York,135-155 (1982).
14. Dohrenwend, B.S. and Dohrenwend, B.P. (eds.), "Stressful Life Events: Their Nature and Effects," Wiley-Interscience, New York (1974).
15. Dohrenwend, B.S. and Dohrenwend, B.P. (eds.), "Stressful Life Events and Their Contexts," Neale Watson, New York (1981).
16. Holmes, T.H. and Rahe, R.H., The Social Readjustment Rating Scale. J of Psychosom Res, 11:213-18 (1967).
17. Barrett, R., Rose, R.M. and Kleinman, G.L., "Stress and Mental Disorder," Raven Press, New York (1979).
18. Brown, G.W., Contextual Measures of Life Events, in Dohrenwend, B.S. and Dohrenwend, B.P. (eds.), 187-201 (1981).
19. Mechanic, D., Some Problems in the Measurement of Stress and Social Readjustment. J of Hum Str, 1:43-48 (September 1975).
20. Brown, G.W. and Harris,T., "Social Origins of Depression: A Study of Psychiatric Disorders in Women," Free Press, New York (1978).
21. Cobb, S., Social Support as a Moderator of Life Stress,

Psychosom Med, 38:300-14 (September-October 1976).
22. House, J.S., Robbins, C., and Metzner, H.L.,The Association of Social Relationships and Activities with Mortality: Prospective Evidence from the Tecumseh Community Health Study, Amer J of Epidem 116 (July 1982).
23. House, J.S., "Work Stress and Social Support," Addison-Wesley, Reading, Mass.(1981).
24. Stein, L.I. and Test M.A., Alternatives to Mental Hospital Treatment I. Conceptual Model, Treatment Program and Clinical Evaluation, Arch of Gen Psych, 37:392-397 (1980).
25. Stein, L.I. and Test M.A., Alternatives to Mental Hospital Treatment III. Social Cost, Arch of Gen Psych, 37:409-412 (1980).
26. Weisbrod, B.A., Test, M.A. and Stein, L.I.,·Alternatives to Mental Hospital Treatment II. Economic Benefit-Cost Analysis, Arch of Gen Psych, 37:400-405 (1980).
27. Mechanic, D. "Future Issues in Health Care: Social Policy and the Rationing of Medical Services," Free Press, New York (1979).
28. McCord, J. A Thirty-Year Follow-up of Treatment Effects, paper presented at the meetings of the American Association of Psychiatric Services for Children (1976).
29. Robins, L.N., Follow-up Studies of Behavior Disorders in Children, in "Psychopathological Disorders of Childhood," (2nd edition). Quay, H.C. and Werry, J.S., eds. Wiley, New York (1979b).
30. Wing, J.K. and Brown, G.W., "Institutionalism and Schizophrenia: A Comparative Study of Three Mental Hospitals, 1960-1968," Cambridge University Press, Cambridge (1970).
31. Pasamanick, B., Scarpitti, F.R. and Dinitz, F.R., "Schizophrenics in the Community: An Experimental Study in the Prevention of Hospitalization," , Appleton-Century-Crofts, New York (1967).
32. Davis, A., Pasamanick, B. and Dinitz, S., "Schizophrenics in the New Custodial Community: Five Years After the Experiment," Ohio State University, Columbus (1974). 33.
33. Segal, S.P. and Aviram, U., "The Mentally-Ill in Community-Based Sheltered Care: A Study of Community Care and Social Integration," Wiley-Interscience, New York (1978).
34. Stotsky, B.A.,"The Nursing Home and the Aged Psychiatric Patient," Appleton-Century-Crofts, New York (1970).
35. Vladeck, B. "Unloving Care: The Nursing Home Tragedy," Basic Books, New York (1980).
36. Wing, J.K., Evaluating Community Care for Schizophrenic Patients in the United Kingdom, in Roberts, L.M., Halleck, S.L. and Loeb, M.B. (eds.), "Community Psychiatry," University of Wisconsin Press, Madison (1966).

DUBLINERS - SOCIAL NETWORKS AND NEUROSIS IN AN IRISH CITY

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INTRODUCTION

It is a fundamental principle of the scientific method that clearly stated hypotheses must be tested not just on one occasion but repeatedly. Unless observations can be reproduced independently in different research and laboratory settings using the same or closely comparable methods, there will always remain some doubt concerning original reports. This principle is taken for granted by basic scientists and yet in social and epidemiological research in psychiatry it is followed all too infrequently.

In relation to social network research in psychiatric disorders, one replication study has appeared which confirms that neurotically depressed psychiatric out patients nominate smaller primary social networks, report fewer social contacts and less social interaction during a sample week before being interviewed, compared with an individually matched, healthy, general population control group (Brugha et al., 1982). The original report of very similar findings (Henderson et al., 1978) has since been over shadowed by a prospective epidemiological study in the general population (Henderson et al., 1981) which reported that the availability of personal social relationships over a one year period was remarkably stable and virtually unrelated to the onset of minor neurotic disorders.

Brugha (1984) has since found that in depressives and healthy subjects there is no relationship between recent exit events and reduced social network size. This author has suggested that small social networks are unlikely to act causally though they may be associated with an increased risk of developing episodes of minor depressive disorders.

If social network deficiencies are indeed relatively stable over time, it will be important to establish whether measures of social contacts and interaction, which have also been shown to be quantitatively deficient in depressed out patients, are independent of nominated primary social network size. This issue can be resolved by examining social contacts and social interaction rates after controlling for social network size. It is therefore hypothesised that patients will contact a significantly smaller proportion of those whom they nominate as members of their primary groups and will spend significantly less time with each person contacted.

Methods

A sequence of 50 newly referred non psychotic, psychiatric out patients were interviewed at St. Vincent's hospital Dublin during 1979 and 1980 (Brugha et al., 1982). Each was matched according to age, sex, marital status and occupation with a healthy control, with no current physical illness or history of psychiatric illness. These were located through primary health care physicians in Dublin.

Each subject was interviewed by means of the Social Interaction Schedule (Henderson et al., 1978) and asked to nominate close relatives and good friends and report contacts and social interaction with them during the previous week. The Present State Examination and CATEGO algorithm were used to categorise the symptoms of the patients (Wing et al., 1974). The 60 item G.H.Q. was also used to screen out cases and controls who did not score respectively above and below the cut off score of 12 (Goldberg, 1973).

Results

In general it was found that by controlling for nominated primary group size, the 50 patients and their controls contacted similar proportions of their primary group. They also spent similar amounts of time in social interaction with each member contacted. Patients with more severe depressive disorders (CATEGO Class R) contacted a modest but statistically significantly larger proportion of their nominated primary group than did their matched controls.

Table 1

Group T-tests comparing the proportion of each subject's primary group contacted and mean hours interaction per contact in past week

	CASE	CONTROL	p(2 tail)
ALL PATIENTS AND CONTROLS			
Proportion of nominated primary group contacted during previous week	68%	60%	n.s.
Mean hours with each member contacted	6.2 hours	5.2 hours	n.s.
NEUROTIC DEPRESSION (CATEGO N) 19 CASES			
Proportion of nominated primary group contacted during previous week	60%	63%	n.s.
Mean hours with each member contacted	5.7 hours	6.1 hours	n.s.
RETARDED DEPRESSION (CATEGO R) 17 CASES			
Proportion of nominated primary group contacted during previous week	77%	55%	.006
Mean hours with each member contacted	7.8 hours	4.2 hours	n.s.

Discussion

These analyses suggest that rates of social contacting and social interaction are a function of the available primary social network size (as it is perceived by the subject). These findings may not however be generalisable to all kinds of non psychotic psychiatric disorders. Previous reports on the relationship of social network factors and life events to PSE-CATEGO categories of depression have also drawn attention to traditional clinical classifications of different forms of depressive disorders (Brugha et al., 1982, Bebbington et al., 1981, Brugha and Conroy, 1983).

It could however be argued that social contact rates are the most objective measures and the number of others nominated as affectively close are relatively less objective social network measures in this study. Although both are interrelated, it is important to assess each in any future research. Taken with the evidence that suggests that social network size is relatively stable over time it appears unlikely that deficiencies in social contacts and amounts of social interaction act causally in the onset of episodes of depression. They may however increase the risk of such episodes developing in the presence of another environmental precipitant such as a stressful life event. Further work is now proceeding on the relationship to depressive disorders of social support in relation to threatening life events, social network size and social contact rates.

Acknowledgement

I would like to thank the Medical Research Council of Ireland and my colleagues at St. Vincent's Hospital, Dublin for their support in this project.

References

Bebbington, P.E., Tennant, C. and Hurry, J. 1981. Adversity and the nature of psychiatric disorder in the community. Journal of Affective Disorders, 3, 345-366.

Brugha, T., Conroy, R., Walsh, N., Delaney, W., O'Hanlon, J., Dondero, E., Daly, L., Hickey, N., and Bourke, G. 1982. Social networks, attachments and support in minor affective disorders: A replication. British Journal of Psychiatry, 141, 249-255.

Brugha, T. and Conroy, R. 1983. Categories of depression, reported life events in a controlled design. (In preparation).

Brugha, T. 1984. Personal losses and deficiencies in social networks. Social Psychiatry, (In press).

Goldberg, D.P. 1972. The detection of psychiatric illness by questionnaire. Institute of Psychiatry, Maudsley Monographs No. 21, London: Oxford University Press.

Henderson, S., Duncan-Jones, P., McAuley, H. and Ritchie, K. 1978 The patient's primary group. British Journal of Psychiatry, 132, 74-86.

Henderson, S., Byrne, D.G. and Duncan-Jones, P. 1981. Neurosis and the Social Environment. Sydney: Academic Press.

Wing, J.K., Cooper, J.E. and Sartorius, N. 1974. The Measurement and Classification of Psychiatric Symptoms - an Instruction Manual for the Present State Examination and CATEGO Program. Cambridge: Cambridge University Press.

SOCIAL SUPPORT IN THE ETIOLOGY OF DEPRESSION: A PANEL STUDY

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INTRODUCTION

The substantial contemporary interest in the epidemiologic functions of social support or social support networks in depression and other disorders is rooted in a number of sources. These include (1) the growing scientific and clinical conviction that stress may be a significant factor in a wide variety of psychiatric and physical disorders. (2) In the epidemiologic literature in particular, the weight of evidence that recent life changes have a significant, if modest, effect on the occurrence of depression leads to a sustained search for clarification of factors which may explain the differential vulnerability of individuals to illness in the context of recent life changes or other stressors. These factors include biological, psychological or social support. (3) The existence of highly suggestive evidence that social support may serve to reduce the risk of illness in the face of stress (the buffering effect of social support). And, (4) the theoretical importance of intimate relationships within the fields of sociology, clinical psychology and psychiatry.

Our own study is one of a number of systematic studies undertaken to ascertain whether and the extent to which an individual's intimate relations with others have any signficant and positive effect on one's mental health. What we wish to present is a historical review of our involvement in this line of research, our approaches to conceptualize and measure social support, and our efforts at modelling the role of social support in the context of the stressors-illness model.

THE ALBANY RESEARCH PROGRAM ON SOCIAL SUPPORT AND HEALTH

A 1977 paper described our views of the status of knowledge regarding the epidemiological functions of stressful life events and social support, emphasizing the need to conceptualize and measure social support (Dean and Lin, 1977). In 1978, we began a research program to carry out these proposed objectives, with funding provided by the Center for Epidemiologic Studies, National Institute of Mental Health. Our program, based on a representative sample of adults from the Albany-Troy-Schenectady area of New York, is known as the Albany Health Study. A pretest was conducted in 1978 in which a sample of 99 respondents provided responses for the formulation and initial scaling of measures. In 1979, the first wave of data was gathered from a sample of 1087 respondents. The second wave and third wave of data have since been gathered in 1980 and 1982. The panel design, therefore, involves three waves of data with gaps of one year (1979-1980), two years (1980-1982) and three years (1979-1982) between data points, allowing estimates of effects of varying time gaps. During the panel period, we have been able to retain over 64 percent of the original respondents.

The remainder of the presentation will highlight three of the issues we have attempted to address and selective findings from the first two waves of the data. The issues are (1) conceptualization of social support, (2) measurement of social support, and (3) modelling social support in the etiology of depression.

CONCEPTUALIZATION AND MEASUREMENT OF SOCIAL SUPPORT

Two strategies have been employed to conceptualize social support. The first strategy called for a classification system in which various elements and components of social support as defined or conceptualized previously in the literature are represented and the second strategy concerned the formulation of a particular theoretical perspective from our own previous work. It was hoped that the two strategies would provide coverage of prevailing understanding of the concept as well as a theoretical focus. In this paper, we discuss progress relating to the first strategy. A discussion of the second strategy is unavailable elsewhere (Lin, 1982, 1983; Lin, Woelfel and Light, 1983).

A review of the discussions in the literature identifies at least four elements of social interactions as central to the concept of social support: (1) the relationships between ego and the source transmitting the help or reinforcement, (2) the channel or network in which such help or reinforcement is transmitted, (3) the message or content of the transmission which conveys or is perceived as help or reinforcement, and (4) the social context within which the trans-

Table 1. Elements and Measures of Social Support

Element	# of Items	Reliability 1979	Reliability 1980	Zero-order Correlation with CES-D T1	Zero-order Correlation with CES-D T2	Source
1. Relationship between ego and source:						
A. Role relationship with confidant	1			.06	.13	Moriwaki, 1973
B. Dimensions of interaction with confidant	7	.75	.81	.12	.23	Kaplan, 1975; Dean & Tausig, in press
C. Homophily of characteristics between confidant & ego						
D. Strong tie support	2	.65	.66	-.44	-.45	Lin & Ensel, 1981; Ensel & Woelfel, in press
E. Family problems	4	.62	.69	.27	.34	Medalie & Goldbourt, 1976; Lin, Dean & Ensel, 1981
F. Adequacy of attachment	61	N.A.	N.A.	N.A.	N.A.	Henderson, et al., 1981
G. Availability of confidant	1	N.A.	N.A.	.01	.08	Lowenthal & haven, 1968; Lin, Dean & Ensel, 1981
2. Channel/Network Support						
A. Problem-role type matrix						
Role-type multiplexity	5	N.A.	N.A.	-.09 to .18		Lin, Woelfel & Dumin, in press
Problem multiplexity	11	N.A.	N.A.	.00 to .08		Lin, Woelfel & Dumin, in press
B. Confidant network						
Size	1	N.A.	N.A.	N.A.	.14	Lin, Woelfel & Dumin, in press
Density of triad network	1	N.A.	N.A.	N.A.	.10	Lin, Woelfel & Dumin, in press
Centrality of ego in triad network	1	N.A.	N.A.	N.A.	.00	Lin, Woelfel & Dumin, in press
C. Most important life event support						
Role relationship	1	N.A.	N.A.	N.A.	-.19	Lin, Woelfel & Light, in press
Dimension of interaction	8	.89	.89	-.09 to .18		Lin, Woelfel & Light, in press
Homophily of characteristics	4	N.A.	N.A.	-.14 to .12		Lin, Woelfel & Light, in press
3. Content/information of support:						
A. Instrumental-expressive support (I-E scale)	26	.69	.70	-.35	-.36	Ensel & Woelfel, in press; Lin, Dean & Ensel, 1981
B. Three factors of I-E scale						
1. Responsibilities/demands	7	.81	.83	-.46	-.47	Ensel & Woelfel, in press
2. Money problems	3	.88	.83	-.33	-.33	Ensel & Woelfel, in press
3. Marriage/love	4	.75	.79	-.42	-.46	Ensel & Woelfel, in press
4. Contectual/social support						
A. Community/neighborhood support	4	.64	.63	.19	.25	Dean & Tausig, in press
B. Participation in organizations, associations	5	.88	.64	-.10	-.08	Dean & Tausig, in press

mission takes place. The elements and measures we eventually incorporated in our study are presented in Table 1.

Also presented in Table 1 are reliability coefficients (alpha values) of the measures and their zero-order correlations with the dependent variable, CES-D (the Center for Epidemiologic Studies Depression Scale), as indications of their construct validity. In general, the reliability and validity are better for two elements: ego-source relations and content-message of support. This is consistent with the discussions and studies by other scholars who tend to focus on these elements in their conceptualization and measurement of social support.

MODELLING SOCIAL SUPPORT IN THE CONTEXT OF LIFE EVENTS & DEPRESSION

There are many ways social support may be conceptualized in the etiology of depression. The focus here will be its relationship with depression relative to life events. This focus was selected because of the prevailing interest in the stressors-illness model and the potential buffering function of social support in this model.

Basically, there are two views about these relations. One view holds that social support, being an indication of the integration of the individual in the social environment, should exert a direct and positive influence on mental health. The second view, a more dominant one in the literature, posits a mediating effect of social support relative to life events.

For this brief discussion, only one measure of social support (the strong tie support) and one measure of life events (summed undesirable life events) will be utilized. First, we examined whether social support serves as a mediating factor between undesirable life events and depression. Or, indeed, undesirable life events also serve as a mediating factor between social support and depression. In the first model, CESD2 (CESD measured at time 2) is regressed on LE1 (undesirable life events measured at time 1) and SS 2 (strong tie support measured at time 2), testing the mediating effect of social support. Figure 1A shows such a model and the results. The data clearly show the mediating effect of SS2. Since the zero-order correlation between LE1 and CESD2 is .23, the model shows that the direct effect of LE1 to be .16, with the remaining effect being indirect and mediated through SS2. The alternative model, viewing life events as the mediating factor between social support and depression is examined in Figure 1B. Since the zero-order correlation between SS1 and CESD2 is -.40, the results also show some mediating effect of life events as the direct path from SS1 to CESD2 has a coefficient of -.15. Our conclusion is that both social support and undesirable events exerts both direct and mediating effects on depression.

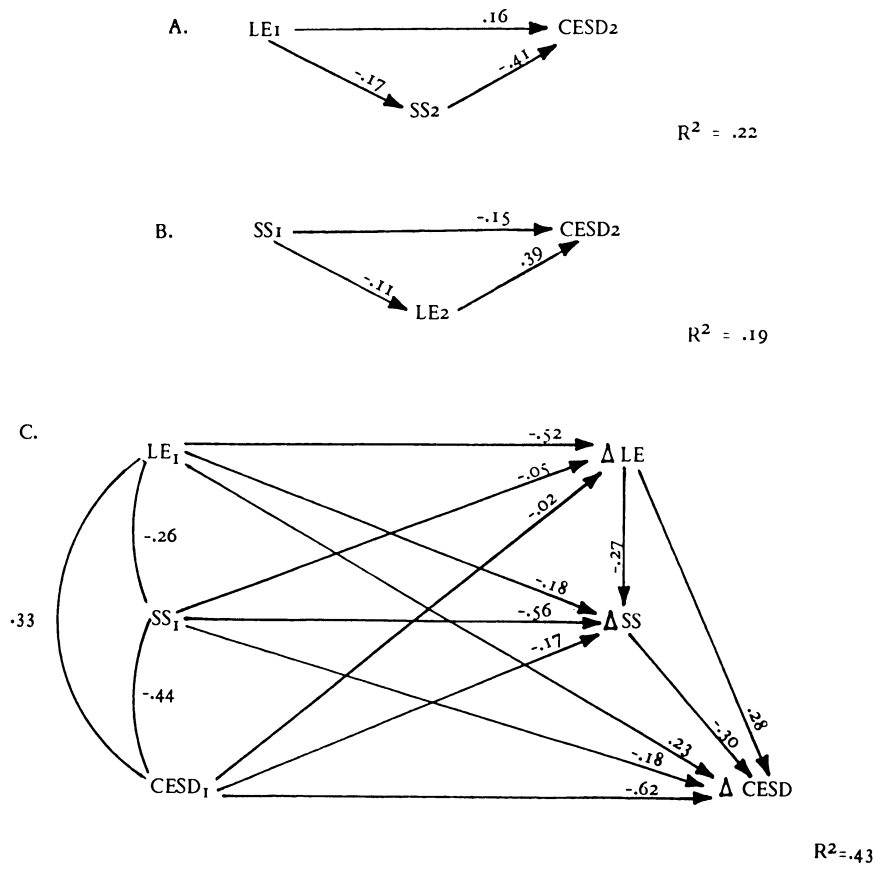

Figure 1. Causal Modelling of Undesirable Life Events, Social Support and Depression

A model taking into account all three variables at both time 1 and time 2 was then examined. Presented in Figure 1C, we constructed change scores between time 1 and time 2 scores for each variable as the endogenous (dependent) variables at time 2. This method avoids potential biases because of multicolinearity effects resulting from high correlations between the time 1 and time 2 measures for each variable (autocorrelations). This analysis further confirms that social support serves as a mediating variable between life events and depression (note the coefficient from LEl to SS and from SS to CESD). There is little support for the mediating effect of life events between social support and depression (note the insignificant path from SSl to LE). Thus, our final conclusions are: (1) both undesirable life events and social support have direct and independent effects on depression, and (2) social support also mediates the effect of undesirable life events on depression.

Currently, we are examining buffering models in which the interactions between life events and social support as well as potential mobilization of social support against the occurrence of an undesirable life events are of major concerns. We have also examined the basic model of stressors-social support-depression relative to other variables (e.g., age, sex, psychological factors and prior illness).

REFERENCES

Dean, A., and Lin, N., 1977, The stress-buffering role of social support, JNMD, 165:403-417.

Lin, N., 1982, Social resources and instrumental action, in "Social Structure and Network Analysis," P. Marsden and N. Lin, eds., Sage, CA.

Lin, N., 1983, Social resources and social actions: a progress report, Connections, Vol. VI.

Lin, N., Woelfel, M., and Light, S., 1983, The buffering effect of social support subsequent to an important life event.

PARENTAL STYLE AS A RISK FACTOR TO PSYCHIATRIC DISORDER

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The view that parents have the capacity to influence the short-term and the long-term development of their children is a tenet of psychiatry, but one that has resisted clear research confirmation. Qualitative theories, which argue for an association between early parental loss or separation and the subsequent development of psychiatric disorder, appear to have been the research pre-occupation until recent times when the quality of the parent-child relationship has attracted closer attention.

It is clearly important that non-trivial parental qualities be studied, and two dimensions (of care and overprotection) are suggested from a number of differing sources. Bowlby (1977) has stated that the roles of a parent or care-giver are, firstly, to provide a secure base and, secondly, to encourage the child to explore from it. According to Bowlby, pathogenic parents differ by being unresponsive or rejecting, and therefore deficient in care, and secondly often invert the normal relationship by exerting pressure on the child to act as an attachment figure - a not uncommon concomitant of over-protection.

Clinical and research reports have also implicated such parental dimensions as relevant to the development of psychiatric and psychosomatic disorders. Lack of parental care and overprotective attitudes are the imputed characteristics of the 'schizophrenogenic mother' (Parker, 1982) and the 'asthmatogenic mother' (Block et al. 1966) while Blatt et al. (1979) have remarked on the consistency of such remembered parental characteristics in the reports of depressives. In fact, a published literature review (Parker, 1983) suggests that such a parental style has been implicated as a causal influence on the development of most categorised child and adult psychiatric disorders.

It is unlikely that such parental dimensions are trivial when numerous factor analytic studies have suggested that the key dimensions of parental attitudes and behaviours are a 'care' one, and one variably termed 'overprotection' or 'control' (Parker et al. 1979; Parker, 1983).

Several years ago we attempted to define these dimensions further and then develop a refined self-report measure of these parental dimensions, the measure being named the Parental Bonding Instrument or PBI (Parker et al. 1979). The final questionnaire has 25 items, and subjects are asked to score each parent on a 4-point Likert scale as remembered in the first 16 years. The 12 'care' items appear to assess a rather homogeneous dimension of warmth, understanding and affection at one end, and indifference and rejection at the other. The 13 'protection' items assess such components of overprotection as control, intrusion, infantilization and encouragement of dependency at one end, and items assessing the encouragement of independence and autonomy at the other. Factor loadings suggest that the items in the final scale are of similar relevance to male and female parents.

It is important to consider the properties of the PBI. The split-half reliability, or internal consistency, of the PBI was assessed in a non-clinical group (Parker et al. 1979) and determined to be 0.88 for the care scale and 0.67 for the protection scale. The test-retest reliability of the PBI has been assessed in clinical and non-clinical groups. In a group of neurotic depressive patients (Parker, 1981) a correlation of 0.90 was found for the care scale, and one of 0.88 for the protection scale, when subjects were tested nine weeks apart. In a group of schizophrenic patients (Parker et al.1982) correlations of 0.68 for the care scale, and 0.71 for the protection scale, were found when testing occurred three weeks apart and when the subjects were tested when they were acutely disturbed by their schizophrenic symptoms and retested after improvement.

The validity of the PBI has been assessed in a number of studies. It is important to emphasise immediately that the PBI was designed to be a phenomenological measure, assessing the perceived characteristics of parents, as we held that the perception of a parent is likely to be far more relevant to childhood and adult development than any 'actual' parental characteristics. Thus we initially assessed the validity of the PBI (Parker et al. 1979) by comparing scores on the measure with scores derived from semi-structured interviews of subjects who were asked to discuss their earlier perceptions of their parents, and we found high correlations with the care scale but moderate ones for the protection scale.

Despite our view that perception of a parent is more likely than actual parental characteristics to influence development, we felt obliged to assess the degree to which the PBI assesses 'actual'

parental characteristics. In one study subjects and their siblings independently completed PBI forms based on their own perceptions and then, on the basis of their observations, they completed PBIs pretending to be their sibling. Validity was assessed by the multitrait-multimethod procedure described by Campbell and Fiske (1959), with the view that the validity of the PBI as a measure of actual parental characteristics would be supported, assuming accurate reporting, if witnesses coroborated subjects' reports and vice versa. A mean correlation coefficient of 0.55, which is higher than that generally found (Crandall, 1976) when validation is attempted using ratings by others, was found but we described several limitations to the procedure.

In a second study, groups of monozygotic (MZ) and dizygotic (DZ) twins were asked to score their parents independently on the PBI. On the care scale the correlation for the MZ twins was 0.71, for the DZ twins it was 0.74, while for unrelated pairs it was 0.05. On the protection scale the coefficient was 0.77 for the MZ twins, 0.86 for the DZ twins and 0.33 for unrelated pairs. The high agreement between twin pairs supports the validity of the PBI, if the possibility of a shared conceptual response bias can be ignored. In a further validity study, university students scored themselves on trait and state depression scales and their mothers on the PBI. Then the mothers were interviewed and asked to complete the PBI forms as they believed thay had related to their child in the first 16 years (Parker, 1981). PBI scores returned by the subjects and by the subjects' mothers, correlated similarly in direction (parental care scores being associated negatively, and parental protection scores positively, with high depression scores) and in strength with mood scale scores supporting, if the shared conception response bias can again be ignored, the validity of the PBI. Further, we showed (Parker et al. 1982) in a prospective study of schizophrenic patients having contact with their parents after discharge, that PBI scores collected in hospital clearly predicted hospital readmission in the nine months after discharge, demonstrating the predictive validity of the PBI.

Finally, PBI protection scale scores discriminated mothers judged at interview as overprotective or not by a rater blind to the PBI scores (Parker and Lipscombe, 1981). These several investigations are encouraging in suggesting that the PBI is an appropriate measure of actual, and not merely perceived, parental characteristics and therefore allow some consideration about causal processes.

In using the measure, raw PBI scale scores may be used in case-control studies but we are particularly attracted to the approach of intersecting, in effect, the scales, allowing four broad styles of parenting to be examined, the technique being described in a recent publication (Parker, 1983). The quadrant high care-low protection

is conceptualised, and supported by our research findings as reflecting 'optimal parenting'. The quadrant high care-high protection is labelled 'affectionate constraint' and our research studies have shown that hypochondriacal and dependent subjects are somewhat more likely to assign one or more of their parents to this quadrant. The quadrant low care-high protection, which is labelled 'affectionless control', defines the pathogenic parenting style so frequently implicated in the literature and appears to correspond with the British notion of high 'expressed emotion' (Brown et al. 1962).

We have assessed the relevance of 'optimal parenting' and 'affectionless control' to a number of psychiatric and psychosomatic disorders, principally by making relative risk calculations as suggested by Paykel (1978). The results from a number of case-control studies are summarised in the table.

TABLE I
INCIDENCE OF PATIENTS ASSIGNING PARENTS TO TWO KEY PBI QUADRANTS

		Relative risk of assigning to			
		High care - low protection ('Optimal parenting')		Low care - high protection ('Affectionless control')	
Disorder	Number of cases/ controls	Mother	Father	Mother	Father
Social phobia	41	0.5	0.5	4.7	4.0
Depressive Neurosis					
. Study 1	50	0.4	0.1	4.7	2.8
. Study 2	125	0.4	0.3	2.2	2.1
Anxiety neurosis	50	0.2	0.1	3.1	2.3
Agoraphobia	40	0.3	0.9	3.6	1.9
Transsexualism	30	0.8	0.1	1.7	4.7
Schizophrenia	72	0.5	0.3	1.6	2.1
Manic-depressive psychosis	50	1.2	1.2	1.4	0.6

The table shows that all patient groups, apart from those with manic-depressive psychosis, were less likely than controls to report exposure to 'optimal parenting' (with relative risks of less than unity being found) and that those with neurotic disorders were least likely to so assign their parents. The table also shows that the risks for assigning parents to the 'affectionless control' quadrant were very high for those with neurotic disorders (eg social phobia, depressive neurosis, anxiety neurosis and agoraphobia) in comparison to those with the psychotic disorders, schizophrenia and manic-depressive psychosis. Such studies quantify and qualify the clinical but rather non-specific observation that patients with psychiatric disorders are likely to describe their parents as uncaring and as overprotective. The findings may be interpreted in several ways and numerous non-causal explanations have been assessed (Parker, 1983) but not supported. While a causal process is not to be argued merely by default there is some evidence to suggest that the increased incidence may reflect a causal process linking parental affectionless control with the later onset of disorder, and in particular with neurosis and several mechanisms have been explored in a recent publication (Parker, 1983).

In conclusion the Parental Bonding Instrument was developed as a simple, refined but rigorous measure of fundamental parental characteristics. It has been extensively assessed in regard to its properties and defines two contrasting parental styles of 'optimal parenting' and 'affectionless control' as negative and positive risk factors respectively to adult psychosocial development. Parental 'affectionless control' appears to be of key relevance as an antecedent to neurotic disorder, and the view that optimal (or socially supportive) parenting involves the provision of care and the absence of overprotection has been supported strongly by the research methodology and quantified for separate psychiatric disorders.

References

Blatt, S.J., Wein, S.J., Chevron, E. and Quinlam, D.M. 1979, Parental representations and depression in normal young adults. J Abnorm Psychol. 88: 388-397.

Block, J., Harvey, E., Jennings, P.H. and Simpson, E 1966, Clinicians' conceptions of the asthmatogenic mother. Arch Gen Psychiatry, 15: 610-618.

Bowlby, J. 1977, The making and breaking of affectional bonds. Br J Psychiatry, 130: 201-210.

Brown, G.W., Monck, E.M., Carstairs, G.M. and Wing, J.K. 1962, Influences of family life on the course of schizophrenic illness. Br J Prev Soc Med, 16: 55-68.

Campbell, D.T. and Fiske, D.W. 1959, Convergent and discriminant validation by the multitrait-multimethod matrix. Psychol Bull 56: 81-105.

Crandall, R. 1976, Validation of self-report measures using ratings by others. Sociol methods Res, 4: 380-400.

Parker, G. 1981, Parental reports of depressives: an investigation of several explanations. J Affective Disord, 3: 131-140.

Parker, G. 1982, Re-searching the schizophrenogenic mother. J Nerv Ment Dis, 170: No.8, 452-461.

Parker G. 1983, Parental Overprotection: A Risk Factor in Psychosocial Development. Grune and Stratton, New York, (in press).

Parker, G. and Lipscombe, P. 1981, Influences on maternal overprotection. Br J Psychiatry, 138: 303-311.

Parker, G., Tupling, H. and Brown, L.B. 1979, A parental bonding instrument. Br J Med Psychol, 52: 1-10

Parker, G., Fairley, M., Greenwood, J., Jurd, S. and Silove, D. 1982, Parental representations of schizophrenics and their association with onset and course of schizophrenia. Br J Psychiatry, 141: 573-581.

Paykel, E.S. 1978, Contribution of life events to causation of psychiatric illness. Psychol Med, 8: 245-253.

Susser, M. 1981, The epidemiology of life stress. Psychol Med, 11: 1-8.

SOCIAL SUPPORT IN NON-PSYCHOTIC PSYCHIATRIC OUTPATIENTS

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INTRODUCTION

During the last decade, the role of social support has been attracting considerable interest in the study of mental disorders.

The social environment, and in particular social relationships are seen as a resource which mediates between stress and health. There is a fair consensus about the deteriorating effect of stressful life events on psychological well-being in the absence of social support.

In their Camberwell study, Brown and his co-workers (1975) identified "lack of a confiding relationship" as one of four vulnerability factors in the development of depression in women. Miller and Ingham (1976) concluded from their study, that both stable and more diffuse social support afforded protection against symptom development during or after periods of adversity. In a very comprehensive study of social relationships, adversity and neurosis Henderson et al. (1980) demonstrated an association between psychiatric morbidity and deficiences in social relationships. In particular they stressed the importance of the perceived adequacy of supporting relationships, especially under periods of adversity for the development of neurotic disorder.

In view of the results mentioned above, we decided to explore the issue of social support both among patients who consecutively attended our outpatient clinic, and in the context of a larger, still on-going study of depressive illness in its various aspects. The findings which will be reported on this occasion, refer mainly to the outpatients and are very preliminary. Those referring to

depressed inpatients will be reported later on together with a more detailed analysis of other relevant factors contributing to the development of non-psychotic depressive disorders.

SERIES AND METHODS

Comprised in this part of the study are patients who attended our outpatient clinic between March 1981 and April 1982. This clinic has the responsibility for the outpatient care for a population of about 90 000 living in Umeå. Only patients presenting non-psychotic disorders have been taken into account at this juncture. Under the heading "non-psychotic disorders" we consider mainly syndromes characterized by the symptomatological pattern of anxiety-depression-sleep disturbances. Diagnostically, these patients would be classified as "anxiety neurosis", "depressive neurosis", "acute maladjustment", "acute stress reaction". Personality disorders and disorders due to alcohol or drug abuse have not been taken into account, nor have a few cases of severe obsessive-compulsive neurosis and anorexia nervosa been, who attended the clinic during the period included. Apparently, the kind of patients considered by us is fairly similar to that studied by Henderson et al. (1981).

A second series of patients, whose results will be mentioned for comparison, is comprised of 25 first admissions for a depressive illness of non-psychotic severity. All these inpatients were, also at their very first episode of illness. They were consecutively collected during a defined span of time.

As a contrast group a series of 98 patients attending a primary-care unit for minor somatic complaints has been collected. Both the inpatients and the contrast series belong to the same

Table 1. The Series

	Diagnosis	N	♂/♀	Age ($\bar{x} \pm$ SD)
Outpatients	Non-psychotic disorder	108	37/71	37.9 ± 12.7
Inpatients	Non-psychotic depression 1st episode	25	7/18	40.7 ± 15.2
Controls	Attendance at a primary care unit for minor somatic disorders *)	98	43/55	43.3 ± 11.7

*) Subjects with psychiatric history excluded

resident population at Umeå in the North of Sweden. The composition of the three series as concerns sex and age is presented in table 1.

Patients in all three series have completed several forms which pertain to the larger study mentioned above. Among the questions they had to answer there were some referring to their perception of having a confiding relationship both within and outside the household. It will be the answers to these questions which will be presented in the results.

RESULTS

The perceived availability of a confiding relationship within and outside the household in our series is shown in tables 2 and 3. As concerns inpatients, the results show that the perception of the lack of a confidant refers more to the household than outside it. Both out- and inpatients show a clearly significant statistical difference in comparison with the patients attending the primary-care unit ($p < .001$): in fact, only a minority among them had the perception of lacking a supporting relationship either within or outside the household. When the outpatient sample had been divided into patients with first and repeated attendances, the results presented in table 4 occur. The lack of a confidant within the household is significantly more common amongst patients with repeated attendances ($p < .05$). In this study age and sex are not related to the availability of a confiding relationship.

DISCUSSION

In line with previous findings in the literature, our results confirm that patients suffering from non-psychotic psychiatric disorder perceive to lack a supporting relationship in whom to

Table 2. Availability of a Confidant within the Household in Different Groups

	N	Available	Not Available
Outpatients	78	57 % (44)	43 % (34)
Inpatients	18	40 % (7)	60 % (11)
Controls	77	91 % (70)	9 % (7)

$\chi^2 = 31.15$, df =2, $p < .001$

The "N:s" are corrected for size of household

Table 3. Availability of a Confidant outside Household in Different Groups

	N	Available	Not available
Outpatients	108	37 % (40)	63 % (68)
Inpatients	25	60 % (15)	40 % (10)
Controls	98	84 % (82)	16 % (16)

$\chi^2 = 46.30$, df = 2, $p < .001$

Table 4. Availability of a confidant in outpatients with first or repeated attendances

	First attendance N = 28 *)	Repeated attendance N = 46 *)
Confidant within household:		
Available	76 % (21)	48 % (22)
Not available	24 % (7)	52 % (24)
$\chi^2 = 4.22$, df = 1, $p < .05$		
	N = 33	N = 75
Confidant outside household:		
Available	42 % (14)	35 % (26)
Not available	58 % (19)	65 % (49)
$\chi^2 = 0.59$, df = 1, n.s.		

*) The N:s are corrected for size of household

confide. Especially stressful this experience seems to be for those people who, in spite of living in a household with a partner or other people, feel a lack of support.

Since our data have been collected from people who had attended a psychiatric outpatient unit or had been admitted to a psychiatric ward, the possibility must be taken into account that the perceptions of lacking social support might be related to help-seeking behaviour and not to the development of a psychiatric disorder, however mild. The conditions of the present study do not allow to solve this issue, which has been accurately considered by other research workers (e.g. Henderson et al., 1981). The significant differences between patients attending the psychiatric units and those attending the primary-care unit suggest that the perception of lacking a supporting social relationship is, at least not related to help-seeking from professionals in general. In fact, only a negligible proportion of the patient seen in primary care for minor somatic complaints has perceived the lack of a confiding person.

As it could be expected, people who lack social support are likely to be found to a larger extent among patients repeatedly attending an outpatient unit than those who do not lack social support. If our results are taken at their face value, it seems that the perceived lack of a confiding person within the household might contribute to the occurrence of a more severe symptomatology requiring admission to an inpatient unit.

In our further studies, an analysis of the data concerning the occurrence and the nature of stressful events, together with an analysis of the personality characteristics of the patients will be taken into account in an attempt to better elucidate the possible role of the perceived lack of social bond in the development of minor psychiatric disorders.

REFERENCES

Brown, G. W., Bhrolcháin, M. N., and Harris, T., 1975, Social class and psychiatric disturbances among women in an urban population, Sociology, 9 (2):225.

Henderson, S., Byrne, D. G., Duncan-Jones, P., Scott, R., and Adcock, S., 1980, Social relationships, adversity and neurosis: a study of associations in a general population sample, Brit. J. Psychiat. 126:574.

Henderson, S., Byrne, D. G., and Duncan-Jones, P., 1981, "Neurosis and the Social Environment," Academic Press, Australia.

Miller, P. McC., Ingham, J. G., and Davidson, S., 1976, Life events, symptoms and social support, J. Psychosom. Res. 20:515.

SOCIAL RISK FACTORS FOR PSYCHIATRIC DISORDERS: BEING YOUNG, POOR AND LONELY

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Study of the relationship between social factors, such as social class or social stress, and mental illness through epidemiologic surveys has a long tradition at Yale University. The tradition began in the 1950s with Hollingshead and Redlich's classic study on social class and mental illness which showed that social class determined treatment for mental illness.[1] The tradition was carried on by Myers and Bean,[2] students of Hollingshead who began a longitudinal community survey in the 1960s and demonstrated the relationship between social stress and mental impairment independent of specific psychiatric diagnosis.[3]

Over the last decade new techniques for improving the reliability and validity of diagnoses have been developed.[3-7]

However, highly trained interviewers with a masters level clinical education were required to administer the instruments since some judgments were required.[7] Thus, the instruments were not practical for use by the ordinary interviewers in large-scale surveys. The Diagnostic Interview Schedule was designed to fill this gap.

THE DIAGNOSTIC INTERVIEW SCHEDULE (DIS)

Briefly, the Diagnostic Interview Schedule (DIS) is a highly structured interview that was designed for use by lay interviewers in epidemiologic studies and is capable of generating computer diagnoses according to some DSM-III, Feighner, or Research Diagnostic Criteria.[8] It is possible to make diagnoses by all three systems

with a single interview because the three systems share a common heritage to the degree that they address diagnoses from a descriptive rather than an etiologic perspective.

The DIS elicits the elements of a diagnosis, including symtpoms, their severity, frequency, distribution over time, and whether or not they can be explained by physical illness, drug or alcohol use, or another psychiatric diagnosis. It is structured both for the questions and the probes, and is precoded so that after editing, answers can be directly entered into the computer. It takes 45 minutes to one hour to administer. Diagnoses can be generated both currently (last 2 weeks, 1 month, 6 months, 1 year) and over a lifetime.

COGNITIVE IMPAIRMENT

Cognitive impairment is assessed by the Mini-Mental State (MMS) developed by Folstein, Folstein and McHugh.[9] The MMS is a simplified, scored form of a cognitive mental status examination which includes 11 questions and requires only 5-10 minutes to administer. It concentrates on cognitive aspects of mental function and excludes questions concerning mood, abnormal mental experiences and the form of thinking.

THE EPIDEMIOLOGIC CATCHMENT AREA PROGRAM (ECA)

With the development of the structured diagnostic assessments, the demonstration of their feasibility in community surveys and the need for accurate information on rates of specific psychiatric disorders, the National Institute of Mental Health organized a 5-site Epidemiologic Catchment Area Program (ECA).

The primary objective of the multi-site longitudinal study is to provide the following information:

1. The prevalence and incidence of specific mental disorders in the community by means of appropriate surveys in single-family households, multiple dwelling units, group quarters, and in institutional settings such as nursing homes, homes for the aged, prisons, schools, and mental institutions.

2. Estimation of the relationship between having a diagnosis and receiving treatment, and when treatment was first initiated; and if not in treatment, the reasons for not seeking and/or receiving treatment.

3. For newly developed mental disorders (incidence), the concomitant risk factors associated with or causative of the disorder.

Yale University in New Haven, Connecticut, received the first such grant, followed by Johns Hopkins in Baltimore, Maryland, and

Washington University in St. Louis, Missouri, and subsequently by Duke University in Durham, North Carolina, and the University of California in Los Angeles.

THE YALE ECA

The Yale ECA consists of the New Haven Standard Metropolitan Statistical Area (SMSA) of nearly one-half million population (427,000 in 1970). There are three field periods with an initial interview, and two interviews of a household sample after six months each (see reference 10 for methods). In the first interview wave of the study, begun in July, 1980, we contacted a systematic probability community sample of 4,000 adults (18 years of age and over) in order to complete at least 3,000 interviews, and an additional sample of nearly 2,7000 persons 65 years of age and older to complete 2,000 such interviews. The data presented today (N=3058) do not include the oversample of older persons. There was a 75.3% completion rate.

Preliminary results on social risk factors and current 6-month prevalence rates of any psychiatric disorders (DSM-III) based on the first wave of the Yale ECA are presented.

SUMMARY OF RESULTS

The overall recent rate of any current psychiatric disorders, including severe cognitive impairment, is 17.4%. Phobia and alcohol dependence, and affective disorders are the most prevalent disorders. The risk factors related to having any current psychiatric diagnosis overall include being young and poor and socially isolated. Interestingly race, sex, and early loss of parent as a child, and presence of young children did not differentially increase risk of psychiatric disorder. Some measures of social isolation may be a consequence rather than a risk factor of a disorder.

The ECA provides a large and rich data base for examining risk factors and psychiatric disorders. This is only the first look. Over the next year we will examine these and other risk factors by specific psychiatric disorders. Most important, we will see how these risk factors vary over one year with the onset of new cases following up the important observation of Henderson and his colleagues.[11] We will also see if these factors are replicated in the other ECA sites in the USA.

ACKNOWLEDGEMENT

The Epidemiologic Catchment Area Program is a series of five epidemiologic research studies performed by independent research teams in collaboration with staff of the Division of Biometry and Epidemiology (DBE) of the National Institute of Mental Health (NIMH).

The NIMH Principal Collaborators are Darrel A. Regier, Ben Z. Locke, and William W. Eaton; the NIMH Project Officer is Carl A. Taube. The Principal Investigators and Co-Investigators from the five sites are: Yale University -- Jerome K. Myers, Myrna M. Weissman, and Gary L. Tischler; Johns Hopkins University -- Morton Kramer, Ernest Gruenberg, and Sam Shapiro; Washington University, St. Louis -- Lee N. Robins, John Helzer; Duke University -- Dan Blazer and Linda George; University of California, Los Angeles -- Richard Hough, Marvin Karno, Javier Escobar, Audrey Burnam, and Diane Timbers.

REFERENCES

1. A.B. Hollingshead and F.L. Redlich, "Social Class and Mental Illness," Wiley, New York (1958).
2. J.K. Myers and L.L. Bean, "A Decade Later: A Follow-Up of Social Class and Mental Illness," Wiley, New York (1968).
3. M.M. Weissman and G.L. Klerman, The epidemiology of mental disorders: Emerging trends, Arch Gen Psychiatry. 35:705-712 (1978).
4. R.L. Spitzer, J. Endicott, and E. Robbins, Clinical criteria for psychiatric diagnosis and the DSM-III, Am J Psychiatry. 132: 1187-1192 (1975).
5. J.E. Helzer, L.N. Robins, J.L. Croughan, and A. Welner, Renard diagnostic interview: Its reliability and procedural validity with physicians and lay interviewers, Arch Gen Psychiatry. 38:393-398 (1981).
6. J.K. Wing, A technique for studying psychiatric morbidity in inpatient and outpatient series and in general population samples, Psychol Med. 6:665-671 (1976).
7. M.M. Weissman, J.K. Myers, and P.S. Harding, Psychiatric disorders in a U.S. urban community: 1975-76, Am J Psychiatry. 135(4):459-462 (1978).
8. L.N. Robins, J.E. Croughan, and K.S. Ratcliff, National Institute of Mental Health Diagnostic Interview Schedule: Its history characteristics, and validity, Arch Gen Psychiatry. 38:381-389, (1981).
9. M.F. Folstein, S.E. Folstein, and P.R. McHugh, Mini-Mental State: A practical method for grading the cognitive state of patients for clinician, J Psychiatric Res. 12:189-198 (1975).
10. J.K. Myers, M.M. Weissman, G.L. Tischler, C.E. Holzer, P.J. Leaf, H. Orvaschel, J. Anthony, J.H. Boyd, J.D. Burke, M. Kramer, and R. Stoltzman, The prevalence of psychiatric disorders in three communities: 1980-1982, Submitted for publication.
11. S. Henderson, D.G. Byrne, and P. Duncan-Jones, "Neuroses and the Social Environment," Academic Press, San Francisco (1981).

GENERAL HOSPITAL PSYCHIATRY AND THE CRISIS OF MODERN PSYCHIATRY

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During the last 15 to 20 years psychiatry has gone through an in depth transformation which affects as much the practical aspects of the provision of services and teaching, as well as its own delimitation and definition of objectives. Still in 1965 the common agreement was that 5 beds per thousand inhabitants were needed for the in-patient care of psychic patients which, unfortunately, generally took part in large and isolated psychiatric institutions. Today the ideal number accepted is around 0.8-1 beds per thousand inhabitants and the emphasis is put upon brief hospitalizations in general hospitals, together with the provision of community services. Only a decade ago, the psychiatrist believed himself to be omniscient, competent on the most diverse human activities, none of which escaped his capacity to scrutinize the most arcane motives of human behavior. Society accepted him that way, proud and in a certain manner harmless, almost alienated behind the walls of the insane asylums or at the couch in the offices of the psychotherapists. Today most of the psychiatrists tend to retract the frontiers of their action and rediscover the medical roots of our discipline. However, while the excesses of hospitalization and the abuses of "psychiatrization" diminish, psychiatry grows in importance, in spite of some of our medical colleagues. The way we practice is transformed as well. A collaborative multidisciplinary work is essential in General Hospital Psychiatry, a work in which the teaching activities are directed towards the psychological training of general practitioners and specialists to deal with that huge mass of problems which we would never be able to take on, and for which psychiatry has developed simply applied technologies.

This situation, crisis we could say, of psychiatry is revealed in two fields. One in the scientific field where Psychiatry debates

between the neurosciences on the one hand and the social and behavioral sciences on the other, with the risk of falling into the temptation of identifying itself with one or the other, loosing therefore its reason for being and running the risk of being absorbed by such powerful neighbors. In the field of patient care, Psychiatry is in the unstable balance between a normalizing function of altered behavior and the abdication inherent in many programs of disinstitutionalization. The excesses in the first extreme have justified the abusive interpretation of the history of psychiatry as a history of the confinement and segregation of irrationality (Foucault).

Basically, this crisis, rather permanent, is an expression of the conflict between two poles towards which psychiatry feels attracted and from which it should flee, since in their purest form they make no sense: psychiatry as an exclusively humanitarian attitude, without the support of scientific and technical knowledge, and psychiatry as an exclusively scientific activity, ignoring human reality.

The number examples of both extremes is plentiful. The flashiest among the recent ones derives from the glorification of the delusions as the announcement of the new man or of the recuperation of the more " authentic" of the human being, which, contaminated with an ideological manipulation, has given place to antipsychiatry. The echo of these currents in the mass media, the squeamishness of some public figures, politicians and health authorities and the defense at all costs of human rights and civil liberties have brought about an authentic manipulation of the human misery which is mental illness. Just a few years have been enough to realize how many programs of disinstitutionalization, premature because they were undertaken without alternatives and trusting in the inexistent benevolence of the citizens, have thrown into a hostile world, chronically ill patients depriving them of almost the only thing they had before (and of course insufficient in many cases), the right to asylum and refuge. This disinstitutionalization has taken place at a most inopportune moment, the time of a prolonged and profound economic crisis, which has doomed to unemployment millions of inhabitants, the majority of them in better condition than the mental patients. Studies carried out in some Spanish psychiatric institutions have shown that the percentage of illiterates among the patients which have been interned for many years is very high and that the degree of instruction received by the majority is very low. How can they be able to compete in a world as hostile as ours? In Italy and in some states of the United States in which disinstitutionalization has taken place with more insistence, those formerly interned wander through the streets, threatened by aggressions and assaults from his fellow citizens, especially drug addicts. Half of the almost 60,000 people who sleep out in the open in New York City have a history

of mental illness, and in some districts of that city it is possible to recognize schizophrenics parkinsonized by doses of depot neuroleptics higher than those they would need in a hospital adding to the negative image which citizens have of mental illness, the dullness, trembling, rigidity and psychomotor retardation characteristic of drug induced parkinsonism. Therefore these programs have achieved precisely the opposite of what, naively, they endeavoured to do. Once more it is necessary to remember that it is not possible to count on the benevolence of society towards mental illness and personal initiatives are necessary (such as the one signified by Father Jofré) to create institutions to protect the insane, the innocent and the helpless (these were the goals of the first Mental Hospital, which was set up by Father Jofré in Valencia in 1411).

Attention should be called also to the abuses on the opposite pole, those derived from the radical application of presumed scientific methods ("ratmorphic" as Koestler would say), sometimes supported by obsolete legislation or applied abusively, and that demand a constant adaptation of the ethical principles which underlie psychiatry.

The excesses and abuses mentioned have been possible because psychiatry, not sufficiently integrated in the development of modern scientific medicine and heir of ancient social commitments, could not confront them adequately.

Modern psychiatry emerges from the confluence of at least two currents which remained very isolated between themselves: the tradition of the confinement and that of pathology which today we would call psychological, represented by entities such as hysteria and hypochondria. These two trends are present in the separation between a "major" and a "minor" psychiatry ("heavy" and "light", H. Ey) and have coexisted with a lack of integration in the development of the rest of medicine, remarkable up to very recent times.

Psychodynamic, ambulatory psychiatry began taking shape round negative notions with respect to the rest of pathology (the neurosis as were defined by Cullen as illnesses without a lesion nor fever). Psychoanalysis and the first psychosomatic, pathology (psychoanalytical in nature), the most orthodox of the Chicago school, didn't succeed in either penetrating sufficiently in medicine nor in mitigating the isolation of psychiatry. The notions of conversion reaction and its correlative psycho-physiological reaction confirm an inoperative dualism, at the same time they fall into the illusion of isolating and describing as a specific pathogenetic reaction that which is no more than everyday bodily expression of psychic contents (Nemiah).

On the other hand, psychosomatic psychoanalytic pathology considers the symptoms as defense mechanisms, and nothing contributes more towards strengthening them than to pay attention to them. In the posthumous work of Alexander (French, Alexander and Pollok) a very significant fact is pointed out. The book explains the results of a prolonged research on the topic of specificity, for which two independent teams of investigators studied the two aspects of each patient, somatic symptomatology and the psychodynamic mechanisms. The study was carried out through a blind methodology. The significant fact is the observation that the study of the clinical symptoms had to be done very early, before the beginning of the psychoanalytic treatment and the therapeutic relation, because once this was established, it contaminated and deformed the symptomatology in such a way that it could not be studied. Also referring to the topic of psychosomatic specificity, Gittleson reached the conclusion that it was better to ignore it, in such a way, that when a psychosomatic patient came to him, his only preoccupation was to initiate a psychoanalytic treatment or establish a therapeutic relation.

These examples permit us to conclude that when, as expression of the isolation of psychiatry and medicine, our colleagues complain about the incomprehensible language that we use they are not simply confirming that we speak in another manner. The truth is that psychoanlytic orthodox psychosomatics not only speaks in another way, but refers to something different.

In the last decades a series of factors and a new attitude have been starting to overcome these barriers of psychiatry, the internal one and the external one: pharmacotherapy, which brought the downfall of therapeutic nihilism, and the advances of biological and psychopathological research and their consequences, the pathogenetic multifactorial concepts. Community psychiatry on the one hand and liaison psychiatry on the other are the bridges established towards a social and medical integration of psychiatry.

During the last few years, the uninterrupted development of scientific and technical medicine of almost two centuries ago, has suffered a sudden brake caused by economic limitations. The expenses in medicine have grown in the industrialized nations until they have surpassed in some cases 7% of the Gross National Product, an amount very near its maximum level, not only because society has many other necessities, but because upon subtracting funds from other aspects (especially education, trade, and consumption, protection of the environment) it would contribute to worsening the health conditions of the community.

Two things seem important to be taken into account at the time of promoting the development of medicine. One, the promotion of community medicine as such, but, above all, its connection to

hospital medicine. Another, to overcome the segregation of psychiatry into the dualism of a medicine of the body and another of the soul in a perspective that has been called multidimensional, holistic, anthropological or comprehensive. Studies on the phenomenology of the body experience in health and in illness, which I have taken up somewhere else are an important theoretical support for these approaches, but there are, furthermore, strong demands based on epidemiological research.

General Hospital Psychiatry requires a very big effort in collaboration. Collaboration in the multidisciplinary teams with other health professionals, collaboration between the diverse psychiatric units among themselves for multicentral research, and above all, collaboration with the non-medical sector of the hospital.

To be concise, General Hospital Psychiatry tries to:

-offer psychiatric patients treatment under conditions analogous to the other patients.
-offer to the medical students with a psychiatric vocation a work perspective comparable to that of his medical and surgical colleagues, and
-participate in the teaching and research possibilities of the rest of our colleagues.

The hospital benefits from this integration because the masked psychic patients or the psychological problems of somatic patients are factors which complicate the actions of the physicians, prolong the hospital stays, provoke the excessive use of costly diagnostic and therapeutic procedures, useless if not risky, and in short, make medicine more expensive. In the Centro Ramón y Cajal the average stay of patients in the psychiatric ward is not superior to the average stay of patients of the hospital and is inferior to that of many who require a costly chain of diagnostic procedures. Furthermore, we found in the requests for consultation that, in some wards, when the physician asks an opinion of the psychiatrist, the time the patient had been admitted to the hospital was higher than the average stay in that same ward. In other wards, the patients who are referred to the psychiatrist come, when they come, are "problem patients" who have exhausted all the costly recourses of medicine, and after there had been a perhaps well founded deterioration of the doctor-patient relationship.

But there is still more. The traditional division between some somatic patients, the "real ones" and the others, the "functional ones", those that have nothing wrong, from an "authentic" medicine, that of the body and the "other medicine", is today rediculous. Aside from the criticisms of the dualistc conceptions of human nature which I have mentioned above, the everyday experience

imposes an unified perspective. Somatic pathology is many times an expression, and others a provoking factor of psychic pathology and vice versa. Coming back to our experience in the Centro Ramón y Cajal, in the patients of consultation and liaison, we have verified that 69% are neither purely psychic, nor purely somatic and that they need a coordinated approach. For this coordination, the lineal models of etiology and pathogenics, which were almost successful in infectious pathology, are insufficient, and it is necessary to resort to others more in accordance with our "Zeitgeist": multifactorial or multidimensional models in consultation psychiatry, and, going a little further, integrative models in liaison psychiatry.

To conclude, I believe that it was due time that our World Psychiatric Association have a Section on General Hospital Psychiatry and we should congratulate them for accepting my proposal. This past January the Section organized, together with the collaboration of the Sections on Training and Education in Psychiatry and Psychosomatic Medicine, a Congress on General Hospital Psychiatry in Madrid where it attracted much attention and the proceedings are already published. I think that future collaboration between Sections of the WPA and other international scientific societies will help to delve into the field of General Hospital Psychiatry to the benefit of our patients and the development of psychiatry.

REFERENCES

Alexander, F, T.N. French and G.H.Polok, 1968 " Psychosomatic Specificity", University of Chicago Press, Chicago and London.

Foucault, M.,1965, " Madness and Civilization: A History of Insanity in the Age of Reason", Pantheon Books, New York.

López Ibor, J.J. and López-Ibor Jr., J.J., 1974, "El Cuerpo y la Corporalidad", Gredos, Madrid.

López-Ibor Jr., J.J., J. Saiz and J.M. López-Ibor, 1983, "General Hospital Psychiatry- a Challenge for the Future of Psychiatry, Excerpta Medica, Amsterdam.

Nemiah, J.C., 1967, Conversion reaction; in:"Comprehensive Textbook of Psychiatry", eds.,A.M. Freedman and H.I. Kaplan Williams and Wilkins, Baltimore.

INTEGRATIVE APPROACH TO GENERAL HOSPITAL PSYCHIATRY: INDICES OF USEFULNESS

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ABSTRACT

The aims and practices of the general hospital psychiatric department vary depending on the character of its parent institution, location, degree of sophistication of services, philosphy of admissions, and nuances of treatment methods, training and teaching.

While the general hospital psychiatric department must perform an important role within the entire network of community mental health delivery system, loyalty is to its parent institution and community catchment area. The department should not favor admissions of one category of patients nor should it identify with institutions better equipped to handle chronic patients requiring long-range hospitalization. Indices of usefulness consist of the results of its work within the framework of its goals.

This paper gives an account of the integrative approach of a psychiatric department in a medical center. The nature of integration is described and the indices of usefulness are explored.

INTRODUCTION

The rapid increase of general hospital psychiatric departments in the United States (American Hospital Association, 1982) came about as a result of political pressures (Kennedy, 1963), change in the social value system (Talbot, 1978) and deinstitutionalization. Community-based hospitalization offers good general clincial services, is more humanitarian and usually facilitates easier return of the patient to the family, community and employment. General hospital psychiatric departments bring psychiatry into the mainstream of

medicine thus facilitating the psychosocial management of non-psychiatric patients (Gover, 1973).

The models of care of "closed unit" systems in teaching hospitals (Greenhill, 1979) and open staffs in others, always utilize a multidisciplinary team headed by a psychiatrist. The aims of care may require a strict selection of patients excluding those who may have to be certified (Flamm, 1981) but others cater more to the community irrespective of the diagnostic category excepting those requiring long-range hospitalization (Greenhill, 1979). With proper methods of intensive care most acute cases can be hospitalized, save for those who do not profit from hospitalization, such as severe character disorders. Difficulties, however, lie not in aims, but in the shortage of qualified personnel, which exists in some regions. In such areas, flexibility and innovative methods of care must be introduced.

This writer has tested empirically for some 7 years an innovative method of integrative approach (Krakowski, 1981;1983). The Mental Health Unit (MHU) is an in-patient department of psychiatry and a part of a 500-bed secondary teaching hospital in northeastern New York. The catchment area of 150,000 comprises 4 counties known for the high rate of poverty. While all specialties are well represented, there is a shortage of psychiatrists apparently due to geographic isolation. MHU is professionally autonomous and supplies liaison and emergency room services; administratively however, it has always been a part of the department of medicine. It is through this unique arrangement that integration with other departments is facilitated. Admissions are strictly to and by psychiatrists but other physicians are encouraged to follow up the referred cases and serve as consultants when needed.

This paper will describe the integrative service within the department, the hospital and the community and will explore the indices of usefulness.

THE NATURE OF INTEGRATION

Figure I summarizes integration of psychiatric services.

Intra-unit integration. The method emphasizes group evaluative and therapeutic activities, group interaction of personnel and group involvement of families and referring agencies. Traditional individual methods are, naturally used. Strong emphasis is placed on family involvement. Group work includes the traditional milieu therapy, group psychotherapy and occupational therapy, but the emphasis is on a host of innovative group methods aimed at decreasing anxiety, depression and anticipatory separation anxiety at discharge. Individual psychotherapy and group psychotherapy are a minimum of 4 and 5 sessions a week respectively. The patient-

personnel interaction is centered around: 1. group rounds conducted daily by attending psychiatrists assisted by staff, 2. group conferences with familes and referring agencies conducted weekly, 3. weekly diagnostic staff conferences, 4. daily progress conferecnes, 5. weekly staff attitudinal-therapeutic conferences, 6. emergency meetings with patients and 7. other group therapies.

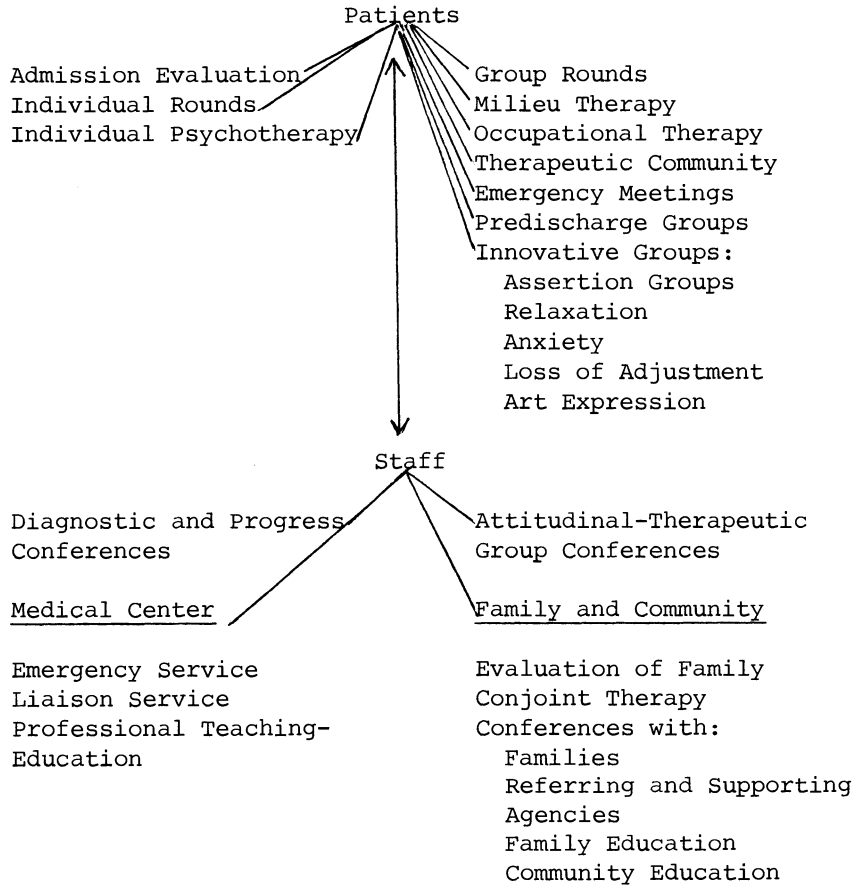

FIGURE I
INTEGRATION OF PSYCHIATRIC SERVICES
In Mental Health Unit

1. Group Rounds proved a superior replacement for individual rounds permitting continuous observation of the patient with regard to his adaptational and coping qualities. Individual attention is given upon demand though requests are only rarely expressed; this occurs more often with initially regressed dependent patients. Most individual problems are worked through in individual psychotherapy.

2. Group Conferences with Families and Agencies are similar to group rounds with patients (Krakowski, 1981,a). Non-attendance is explored for clues regarding the attitude of the family toward the patient. Families are given information regarding diagnosis and treatment and are "educated" about the post-treatment expectations and management.

3,4. Weekly Diagnostic and Daily Progress Staff Conferences are standard.

5. Emergency Meetings with Patients again require no elaboration except that they serve to prevent or alleviate complications caused by unusual circumstances.

6. Attitudinal-therapeutic Staff Conferences represents weekly meetings of modified group therapy to prevent countertransference disturbances, strained staff relations and polarization. The method is dictated by the stress of the liberal admission policy resulting in the necessity of utilizing a flexible approach ranging from strict limits for some patients and unstructured management for others. With proper guidance and therapy, cohesiveness of the members of the therapeutic team is generally improved with intra-staff friction and improved professionalism.

7. Other Group Therapies. Therapeutic community sessions are administratively useful but have proved of little clinical value. The more innovative and useful ones are art expression group, relaxation group, anxiety group, loss of adjustment group and pre-discharge group.

The integration of the staff is facilitated by a continuous flow of information from patients to staff and among the staff members. This is possible only with the application of the group aspects of the program.

Integration with Medical Center. This is created and maintained through the active role that the primary care (referring)physicians and consultants play in MHU. The other tools are the emergency room work, and most important, the psychiatric liaison service (Krakowski, 1981,b), whose research projects have been previously reported (Krakowski, 1971; 1972; 1973,a,b,c,; 1975; 1976; 1981,b; 1982,a,b). Education efforts have been fruitful in the work process and in yearly psychosomatic seminars, a tradition of 10 years.

Integration with Community is achieved through direct contact with the community network of supportive agencies, weekly conferences with representatives of clinics, day care centers, workshops and hostels of the Association for Retarded Children.

Total integration is viewed in the light of general systems

theory (von Bartalanffy, 1968; Miller, 1978). MHU, as other departments, is an open system, a subsystem of the medical center, a suprasystem. Such subsystems influence each other continuously through their flexible and penetrable boundaries. To achieve this, MHU facilitates interaction with other subsystems. While a subsystem of the medical center, MHU is also a suprasystem in its inner workings. The senior psychiatrist must assume a dual role, that of a suprasystem directing the work of others, and a subsystem in his role of therapist.

The success of the entire system consists of inter-system collaboration and exchange of information. Internally no subsystem may usurp the role of a suprasystem believing that his/her role is more essential than the role of others. In this sense the effectiveness of work depends upon the leadership of the person in charge (the suprasystem) and the collaboration of the personnel (subsystem)

INDICES OF USEFULNESS

For an innovative method to be satisfactory it must show results similar to those reached by a traditional method. This was exposed to a statistical overview.

Patients admitted to MHU from January 1-May 31, 1982 were compared to the group of patients in its parent institution, Champlain Valley-Physicians Hospital Medical Center (CVPH), and a "selected sample" of upstate New York general hospitals which admit patients with a diagnosis of mental disorder irrespective of whether or not they have a separate psychiatric department (N.Y.S.H.A., 1982).

TABLE I

COMPARISON OF PATIENTS WITH DIAGNOSIS OF MENTAL ILLNESS IN CV/PH MEDICAL CENTER AND A "SELECTED SAMPLE" IN NEW YORK STATE

	CV/PH	"Selected Sample"
Size of Group	562 patients	8,448 patients
Average Age	47.2 years	40.2 years
Length of Stay	17.1 days	13.0 days

From Table 1 it is seen that CVPH admits a larger percentage of patients with mental disorders as compared with a vast number of hospitals represented in the "selected sample"*. This may be due to stricter admission policies in the latter hospitals and availability of psychiatric beds in governmental psychiatric centers.

*Non teaching hospitals outside of New York City.

The figure regarding CVPH admission may also be larger because of the availablity of liaison psychiatrists and therefore better diagnostic classification. The average age and length of stay are higher in CVPH possibly because of distances in the CVPH catchment area of up to 100 miles.

Table 2 Shows a comparison of diagnostic categories in CVPH (including MHU) and the "selected sample", by frequency of admissions, diagnosis and the average length of stay.

In evaluating the figures reported in 20 different diagnostic categories (ICD-9, 1980) some were eliminated when the frequency was minimal, others condensed (e.g, all affective psychoses were placed in one category) into 12 categories to make the comparison easier and to fit the MHU categories.

It is determined that CVPH admits more patients with diagnoses of affective psychosis, senile/presenile psychosis and personality disorders, than the "selected sample" hospitals. However, the latter group admits, more frequently, patients with alcohol dependence syndrome, adjustment reactions, alcoholic psychoses and non-dependent drug abuse. Pattern of admissions of neurotic and schizophrenic patients showed insignificant differences.

CVPH has generally a longer length of stay, though some of the categories such as affective psychoses, schizophrenia and senile/presenile psychoses do not differ significantly. This disproportionate length of stay in non-psychotic brain syndromes appears to be due to the lack of nursing home beds and skilled nursing facilities in the area.

The statisitical overview of the MHU during the same period is shown on Table 3 which portrays admissions by diagnostic frequency, the percentage of the total MHU admissions, average age and average length of stay.

It is clear that there is little difference between MHU and its parent hospital with regard to diagnostic groups. The uniformly longer length of stay in MHU results from policies and goals and the fact that patients admitted to MHU are more severely ill vis a vis those admitted to the non-psychiatric part of the hospital. It is also clear that those admitted to MHU were in the acute phase of illness or exacerbation of chronic illness which featured risks.

CONCLUSIONS

An innovative method of patient care in the psychiatric department of a general hospital is described. The method is integrative

TABLE II

COMPARISON OF PATIENTS IN CVPH WITH "SELECTED SAMPLE" BY FREQUENCY OF ADMISSIONS AND LENGTH OF STAY

January 1-May 31, 1982

CVPH		"SELECTED SAMPLE"	
Diagnosis	LOS	Diagnosis	LOS
Affective Psychosis	14.0	Alcohol Dependence	13.0
Neurotic Disorders	20.3	Schizophrenic Disorders	12.3
Schizophrenic Disorders	13.5	Neurotic Disorders	13.9
Alchohol Dependence Syndrome	18.1	Affective Psychoses	12.5
Senile/Presenile Psychoses	18.1	Adjustment Reactions	14.5
Personality Disorders	19.8	Alcoholic Psychoses	11.0
Special Symptoms NEC*	14.6	Non-Dependent Drug Abuse	8.6
Alcoholic Psychoses	16.6	Non-Psychotic Brain Syndrome	26.3
Physical Conditions Arising from Mental Factors	9.5	Other Non-Organic Psychoses	26.3
Other Non-Organic Psychoses	19.5	Senile/Presenile Psychoses	17.5
Adjustment Reaction	17.8	Personality Disorders	13.5
Non-Organic Brain Syndrome	52.9	Affective Psychoses/Other	13.6

*Not Elsewhere Classified

TABLE III

PATIENTS ADMITTED TO MHU, JANUARY 1-MAY 31, 1982 BY DIAGNOSIS, FREQUENCY (N) AND PERCENTAGE (%) OF ADMISSION, AVERAGE AGE AND AVERAGE LENGTH OF STAY

Diagnosis				
Neurotic Disorder	58	34.5	46.6	17.8
Affective Psychoses	41	24.4	52.4	21.4
Schizophrenic Psychoses	19	11.3	42.0	24.3
Alcohol Dependence Syndrome	13	7.8	46.9	15.0
Senile-Presenile Psychoses	12	7.1	72.5	18.0
Adjustment Reactions	8	4.8	36.8	19.5
Personality Disorders	5	2.9	33.2	18.2
Other Organic Psychotic Conditions	4	2.4	37.5	24.2
Disturbances of Conduct	4	2.4	24.2	24.2
Mental Retardation, Mild	2	1.2	33.0	23.5
Drug Dependence Syndrome (Non-Organic)	1	0.6	22.0	37.0
Special Syndromes NEC*	1	0.6	34.0	55.0
Total	168	100.0	47.0	19.9

*Not Elsewhere Classified.

and utilizes both individual and group approaches, interpreted in the framework of general systems theory.

For the psychiatric department of the general hospital to be useful it must fulfill the local needs as well as policies and resources of the parent institution along with those of the catchment area with geographical, cultural and social demands. MHU appears to have fulfilled this role in a satisfactory fashion despite limited resources and qualified personnel. Its standards of care have been licensed by New York State Department of Mental Health and the Joint Commission of Accreditation of Hospitals.

Although the stay of admitted patients was comparatively greater than the length of stay in the quoted "selected sample", MHU fulfilled its needs in a wide range of diagnostic categories requiring a non-stringent selection. It is felt that integrative approach and its success represent the positive indices of usefulness.

REFERENCES

American Hospital Association Annual Survey, 1981.

Cartwright, A.: Human Relations and Hospital Care. London, Ruttledge and Kegan Paul, 1964.

Flamm, G.H.: General Hospital Psychiatry: Structure of Concept. Gen. Hosp. Psychiatry. 3: 315-310, 1981.

Gover, D.D.: Considerations in Providing Psychiatric Services in General Hospitals. Hosp. Community Psychiat. 24: 252-252, 1973.

Greenhill, M.H.: Psychiatric Units in General Hospitals: 1979. Hosp. Community Psychiatry 30: 169-182, 1979.

ICD-9: International Classification of Disease. Edward Brothers, Inc. Ann Arbor, Michigan, 1980.

Kennedy, J.F.: Message from the President of the United States Relative to Mental Illness and Mental Retardation, 99 Congress, 1st Session, February 5, 1963. HR document No. 58.

Krakowski, A.J.: Doctor-Doctor Relationships, Psychosomatics 12: 11-15, 1971.

Krakowski, A.J.: Doctor-Doctor Relationships II: Conscious Factors Influencing the Consultation Process, Psychosomatics 13: 158-164, 1971.

Krakowski, A.J.: Doctor-Doctor Relationships III: A Study of Feelings Influencing the Vocation and Its Task, Psychosomatics 14: 156-161, 1973.

Krakowski, A.J.: Role of Consultation Psychiatry in Teaching Psychopharmacology in the General Hospital, N.Y.S.J. Med. 73: 1987-1991, 1973.

Krakowski, A.J.: Liaison Psychiatry: Factors Influencing the Consultation Process, Int. J. Psychiat. Med. 4: 439-446, 1973.

Krakowski, A.J.: Psychiatric Consultation in the General Hospital: An Exploration of Resistance, Dis. Ner. Syst. 38: 242-244, 1975.

Krakowski, A.J.: The Meaning of Death in Psychodynamics of Medical Practice, Dynamishe Psychiatrie 8: 240-253, 1975.
Krakowski, A.J.: Psychosomatic Aspects of Aging, Psychiat. J. Univ. Ottawa, 1: 150-155, 1976.
Krakowski, A.J.: Psychiatric Consultation for the Geriatic Population in the General Hospital, Bibliotheca Psychiat. 159: 163-185, 1979.
Krakowski, A.J.: Liaison Psychiatry: A Service for Averting Dehumanization of Medicine, Psychother. Psychosom. 32: 164-169, 1979.
Krakowski, A.J.: Psychiatry in the General Hospital: Liaison with Families, Psychiat. J. Univ. Ottawa, 6: 175-179, 1981.
Krakowski, A.J.: Liaison Teaching of Psychosomatic Medicine to Physicians and Nurses, Proceedings 13th European Confernce on Psychosomatic Research, Koptagel-Ilal (ed.) Soc. of Psychosom. and Psychother. Istanbul, pp. 131-137, 1981.
Krakowski, A.J.: Stress and the Practice of Medicine--The Myth and Reality, J. Psychosom. Res. 26: 91-98, 1982.
Krakowski, A.J.: Stress and the Practice of Medicine II: Stressors, Stresses and Strains, Psychother. Psychosom. 38: 11-23, 1982.
Meissner, W.W. and Nicholi, A.M.: The Psychotherapies: Individual, Family and Group, in Nicholi, A.M. (ed.) The Harvard Guide to Modern Psychiatry, Cambridge, Harvard Univ. Press, 1978.
Miller, J.G.: The Living System, New York, McGraw-Hill, 1978.
Parsons, T: The Social System, New York, The Free Press, 1951.
Talbot, J.A.: The Death of the Asylum: A Critical Study of State Hospital Management, Services and Care. New York, Grune and Stratton, 1978.
Uniform Information Service, New York State Hospital Association, 1982.
von Bartalanffy, J: General Systems Theory, New York, George Brasillar, 1968.
Weisman, A.D.: On Dying and Denying: A Psychiatric Study of Terminality. New York Behavioral Publications, 1972.

NEW DIMENSIONS IN LIAISON CONSULTATION

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ABSTRACT

The role of the Liaison Consultation physician and psychiatrist is examined in terms of its change. Not only does the liaison person assess, diagnose, and identify therapeutic processes for the psychosocial aspects of medical and surgical illness, but he or she is frequently requested to participate with family members and nurse-physician teams in decisions relating to medical ethics. Several examples will be presented illustrating this expansion of roles and interactions. These will include: decisions regarding the termination of life support systems; patient's refusal to accept the amputation of a gangrenous limb or the patient who no longer desires to live.

New Dimensions in Liaison Consultation

In addition to the Consultant's investigative and advisory roles in working with medical and surgical patients and their physicians regarding psychosocial problems, the role of the Consultant has become increasingly that as a participant in arbitrating decisions in which ethical issues are involved. In most situations, the Liaison psychiatrist is as poorly equipped to participate in these decision-making processes as his colleagues. What experience he or she has obtained has been through his/her naive participation in the situations of conflict between interested parties. Since these decision-making processes are increasingly frequent in cases involving psychiatric consultations and because many of these are value-

laden in terms of an individual's interests or ethical position, the liaison physician has been drawn into these areas of inquiry. Partly because of this spontaneous occurence, partly by predisposition and largely because the controversies that arise identify problems in human behavior, liaison psychiatrists have become sensitive to ethical issues in medicine. As a result, many have become absorbed in the study of ethical issues in order to understand the position of their colleagues and patients. Psychiatry, of course, has its own share of dilemmas involving ethical concerns, not the least of which involves court-related commitments based upon information reported by psychiatrists. Psychiatrists are also participants in insanity defenses and expert witnesses in a host of problems bearing on sociopathy and mal-practice disputes.

The Liaison Psychiatrist's Role in Decision-Making

To a large extent, the psychiatrist's role as a participant in decision-making has been foisted on him. This is generally true of an outsider, who while a member of the medical team is also at once an outsider inasmuch as his specific expertise and orientation is concerned. As an outsider, he takes a more distant overview of the situation and catches nuances with his third ear, which alerts him to the subtleties and nuances of the controversy. In addition, through his experience and growing interest in how ethical stances may influence decisions, he brings a different view to the conflictful dilemma. As a physician-psychiatrist, she or he adds dimension to the issue by virtue of attentiveness to affective, as well as cognitive deliberations. As an outsider, she or he is more astute in identifying inconsistencies and biases in the position of others. As a participant, she or he may frequently be aware of these in him- or herself, thereby empathizing, as well as identifying with the positions of others. The role of the physician-psychiatrist in arbitrating difficult decision-making processes is augmented by his on-going familiarity and knowledge of the common and uncommon dilemmas that are presented to him.

The Situation in Which the Psychiatrist Participates

The situation in which the liaison psychiatrist is most likely to participate is when there are differences between members of the patient care team. This is especially the case in which one or more parties to the conflict has become fixed in an unalterable and occasionally untenable position. These may be based on attitudinal differences of long-standing or upon underlying attributes relating to personality variables. Conflict is most likely when affect-laden positions are annealed with doctrinaire positions based upon fixed ethical and/or religious positions.

Such conflict-laden situations may exist between patient and doctor, patient and family, family and doctor, doctor and physician-

consultant, nurse and doctor, parent and parent, hospital and doctor, hospital and society, hospital lawyer and doctor, and ultimately, the Court and all of the above-stated individuals.

What May be the Basis of the Conflict

Leaving personality and affective aspects aside, the basis of conflict frequently evolves from controversies regarding investigative, diagnostic and treatment approaches. The practice of Medicine is an ideal forum for this, inasmuch as the ancient distinctions between practices continue to exist, as well as to propagate. Despite increasing cooperation and collaboration between medical and surgical sub-specialties, there remain distinct differences in both cognitive and conative processes that sometimes compete with one another. Pharmacological and surgical approaches, while increasingly complementary, are also at times competitive, as well as sometimes equivocal. In mental health and psychiatry, both pharmacological and electroshock approaches are held suspect in terms of mind-bending or punishment, respectively, by lay populations and more covertly by some members of the health profession. The matter of institutionalization of individuals with mental retardation and/or psychotic processes is cause for concern and ambivalence, resulting in disagreements within families and among mental health workers. Similarly, within medicine and surgery, both processes of admission and discharge are thwart with differences of opinion regarding necessity and readiness, respectively. These controversies are shared by families and professional staff. They also relate to the appropriate unit of care, e.g., the Intensive Care Unit, as opposed to a general medical or surgical unit.

What Specific Issues may be Identified

Long-standing and still contemporary as marked by a wide range of fixed positions are attitudes and decisions around the issues of abortion. The conflict prevails in spirit, if not always in practice, within Society. Society is involved both through its legal system, as well as through its various parochial institutions and individual citizenry. The conflicts range within families, between spouses, as well as children, between identified patient and physician, between each of these and societal, legislative, and what is referred to as customary practices. Not only is there conflict about the termination of pregnancy, but there are moral positions and legislative decisions regarding the trimesters in which abortion may be sanctioned. From time to time, the State has altered its position in order to decrease or increase its population for its own benefit. A number of practices have developed which relate intimately to those of abortion. Amniocentesis for the purposes of identifying genetic-transmitted defects in fetuses or other intrauterine problems affecting maternal health is now a common practice in technologically

sophisticated countries. More recently, there has been controversy surrounding the issue of fetal sex identification by parents desirous of considering abortion in the event that the conceptus is of an undesired sex. Some practitioners refuse to reveal the identity of sex. There is the further issue regarding the use of tissue obtained from abortions or from non-viable neonates in non-therapeutic research and organ-system transplantation into individuals with defective organ systems.

The Allocation of Scarce Resources

An issue generative of equal concern and affect is that of the discontinuance of life support systems in individuals unlikely to regain consciousness. The problem is complicated by such considerations as the quality versus the quantity of life and active versus passive euthanasia. These discussions are frequently phrased in terms of ordinary versus extraordinary or usual or unusual care. These issues are further compromised by the demand for the transplant of such organs as kidney, liver, lung, bone marrow, cornea, and more recently, fetal tissue from these individuals into recipients with defective organ systems. To what extent does demand and competition for organs compromise or interfere with unbiased considerations of the maintenance or discontinuance of life support systems? To what extent are active and/or passive concepts of euthanasia utilized and how are these dictated by the interests of the various parties involved in the decision?

Lobbying groups are now common practices for the interest of special groups of patients. These groups are politically alert in gaining the support of legislative bodies for the demands and needs of their members and others afflicted by chronic illness. Such competition for procedures and services compromise the balanced judgment relative to the proper or rightful distribution and allocation of scarce resources, thereby potentially favoring those with diseases in vogue and disfavoring those with less favored disease entities. Rightful distribution is discussed in terms of individual rights and justice: Who should get these goods? How are goods distributed? Who decides? What are the reasons given for the judgments made? In matters of transplantation of tissues and organs, judgments may first be made on the basis of biological and medical determination: What is the potential of success? Is other disease present? What is the quantity and quality of life left for the individual? Decisions will also hinge on the presence of and willingness of a donor. What is the obligation of the donor? Can he be forced or intimidated by the threat of social ostracism or other means? Do fetuses and non-viable neonates have rights regarding non-therapeutic research or use of organ systems? Who can make equitable decisions in these cases? Distributive justice attempts to determine rights and due deserts of individuals on a basis of mutuality. On a macro-level, the discussion is in terms of

social justice among groups and the specific needs of classes of patients. Needs, equality, individual efforts, societal contributions are not entered into nor arbitrated free of bias and affect, which may affect rational positions. Enthusiasm, hopelessness, helplessness, envy, vying value systems, and scores of other affects and concerns will influence the decisions of patients, families, physicians, and other parties. The liaison physician is a frequent arbiter in these processes by his or her ability to identify the affective and cognitive positions from which the various participants present their views.

How a Liaison Physician Participates in Ethical Decision-Making Processes

Throughout the previous sections, I have addressed the several roles that the liaison physician plays in his participation in the decision-making processes with her colleagues. Emphasizing that her view is both from the outside, as well as from within, she brings a fresh perspective in her observations and formulations to the problems identified by colleagues. In these interactions, the consultant uses her affective and cognitive skills in empathically relating with the concern and dilemmas of the medical staff. She attempts to understand and identify the positions that various members of the team have assumed, leading to a particular stand. In doing this she may identify the vested interest of the oncologist or or his or her adamant position in pursuing one or the other treatment protocols. She may identify contrary feelings and positions generative of anger or neglect in members of the nursing and attendant staff who may have greater feeling and insight of the needs and wishes of the patient. The consultant frequently absorbs and helps resolve the ambivalences and uncertainties of family members who are rarely in agreement with one another regarding a course of action. She may detect a reluctance of family members to adopt responsible positions relative to the wishes of the terminally-ill patient, thereby abnegating themselves from the process in an attempt to place the responsibility on the physician.

The Consultant also assists in identifying irrational factors affecting decision-making processes and assists in sorting out possibilities and probabilities regarding the care of the patient in concert with the professional and family individuals involved. Such sorting processes will involve knowing (and sometimes suggesting) what the delirious or comatose patient would want were he in a rational state of mind. The consultant also needs to know the relative societal attitudes toward particular actions, as well as the common ethical positions, their derivation and potential consequences. A practical aspect of the consultant's role is assisting patients and their families in extraditing themselves from previous fixed positions. The knowledge of living wills and of the services of Hospices and other similar care institutions will

frequently serve patient and family in good stead in accepting and accommodating to a difficult resolution. Some institutions have initiated the role of a patient's ombudsman who is essentially a patient advocate and sometimes a spokesperson identifying and working out problems in the best interest of and acceptable to the patient, family, and staff. The ombudsman brings a fuller range and dimension to the consideration of the patient's total care through his knowledge of ethics and interest in the psychosocial aspects of care.

The Intrinsic Ethic of the Physician

Presumeably, the physician brings to medicine time-honored attributes based upon his development, selection and education as a doctor. First and foremost is the physician's awareness of his motivations, abilities, and competences. Second is the capacity of the physician to know and empathize with the patient. Third is the physician's emphasis on a private and confidential relationship. Fourth is the obligation of the physician to inform the patient of what is proposed in the investigation and treatment and obtaining the patient's consent. Fifth is a commitment to the continuity of care as long as it is necessary and desired, or until transferred with the mutual consent of the patient and receiving physician. Sixth is the commitment of the physician to a scientific approach to accepted diagnostic and therapeutic actions. Seventh is the commitment of the physician to take an active role in the decision-making processes of the patient and his family. Eighth is the physician's awareness of his or her limitations. Ninth is the physician's obligation to know something of the contemporary diaglogues involving the principles of ethics and patient care. Tenth is the physician's commitment to an awareness of advances in research which hold promise for the patient and the physician in their mutual collaboration and hope in the therapeutic process.

APPENDIX

Other Ethical Principles Used in Consideration of Medical Ethics

The following classification of ethical terms are identified as a brief guide to the use of commonly used terms:

General Normative Ethics--a system of fundamental moral principles and rules, universally valid.

Applied Normative Ethics--an example of the application of concepts of justice and utility in the discussion of a specific problem such as the allocation of scarce medical resources.

Descriptive Ethics--addresses the anthropological basis of ethics as it has developed idiosyncratically within a culture.

Metaethics--addresses semantics and the analytic meaning of terms, the logic of moral reasoning as in: what is the case as opposed to what ought to be the case.

Utilitarian Ethics--includes RULE (moral rules)--what is usually right; and ACT (situational)--what is right in the specific time and place. In addition, ethical issues may be addressed from the standpoint of PRINCIPLES, including: AUTONOMY (informed consent, refusal of treatment); NONMALEFICIENCE (active, passive euthanasia, optimal and obligatory, proxy decision-makers); BENEFICIENCE (costs/benefits, paternalism); JUSTICE (rights/obligations, allocation of scarce resources--micro- and macro-).

REFERENCES

Strain, James J., and Hamerman, David, The application of psychological concepts in the hospital-inpatient setting, in: "Psychological Interventions in Medical Practice," J. J. Strain, ed., Appleton-Century-Crofts, New York, 1978, pp. 174-194.

Kimball, Chase Patterson, The ethics of a personal medicine, in: "Symposium on Psychiatry in Internal Medicine," Med. Clin. No. Amer., 61:867-877, No. 4, W. B. Saunders Company, Philadelphia, 1977.

Beauchamp, Thomas L., and Childress, James F., "Principles of Biomedical Ethics," 2nd edition, Oxford University Press, New York, 1983.

Gustafson, James M., Professions as "callings." Social Service Review, The University of Chicago, Chicago, December 1982.

Wallace, Samuel E., and Eser, Albin (eds.), "Suicide and Euthanasia: The Rights of Personhood," University of Tennessee Press, Knoxville, 1981.

Supported in part by National Institute of Mental Health Grant, "Psychiatry: GP Special Training and Liaison Fellowship," Grant No. 5-T01-MH07795-23.

THE ROLE OF THE GENERAL HOSPITAL IN BIOPSYCHOSOCIAL EDUCATION

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INTRODUCTION

Hospitals have, through the ages, exerted great attraction upon novelists, playwrights, cinematographers, photographers, and sociologists. The perverse magnetism of human misery and sickness as well as captivation by the struggle to conquer them are attested to by the millions of viewers who daily can be found entranced by the endless episodes of a television serial called "General Hospital." Whether through counterphobic immersion in the gore of a bloody operation, the technological mastery of mankind's scourges, or the intrigue and romance of relationships which bloom in surroundings where sickness abounds, there is something for everyone.

AFFECT AND SOCIALIZATION OF THE PHYSICIAN

Perhaps one of the most intriguing aspects of human behavior is that it is possible for those who spend most of their occupational lives in such places to actually become inured to the everyday drama and emotional turmoil which exist there. Yet it has been noted that medical students and physicians may be hampered in their work by a too responsive affective reaction to the intensity of life and death experience encountered in the course of their work. It is perhaps this paradoxical professional performance coupled with the mind-body dualism of medical education which obstructs the evolution of a truly biopsychosocial appreciation of the sick person.

Such a microcosm of life's snapshots should ideally be a training ground not only for technical proficiency in diagnosis and treatment but also for exposure to every human and humane encounter.

It is in the setting of the general hospital that the bulk of the medical student's undergraduate and postgraduate education will take place. From the first anxious moments of an introduction to clinical medicine, the student begins to confront in him or herself an abundance of conflict over identity, personal values, sexuality, and human relationship.

Self-image may traverse the gamut from worthlessness or humility to overconfidence or grandiosity. Those individuals lacking the resilience and adaptability to process such vacillating demands on the psyche may traverse their path erratically or not at all. The impressive thing is that so many are able to survive the experience, attracting medical sociologists to study the phenomenon that has been called the professional socialization of the physician.

Some have called attention to the constriction of affect which occurs as adaptive defense for some as they navigate the shoals of medical education. If this constriction is too rigidified, the physician may not only renounce his pre-medical repertoire of human responses but may later on be impregnable to new insights about himself or his patients as he goes about the practice of his profession.

DISEASE-ORIENTED VS. PATIENT-ORIENTED MEDICINE

Besides the shaping of affective response, what is the impact upon the physician of observing encounters with sick individuals whose personal daily schedules and privileges are subjugated to institutional needs? In the hospital, the regressive event of illness is compounded by the frightening exposure to complex incomprehensible machines and procedures which exert a dehumanizing effect on the patient.

Feelings of fear, disgust, uncertainty, or sadness are often experienced as alien to the new physician's task. Efforts to master such feelings and to cope with unwanted emotion often attract the student toward task-oriented, operational, precisional, and laboratory-aided medical decisions at the expense of incorporating personal, humanistic responses into a treatment and management plan.

By the time the medical student becomes an intern and then a medical resident, further reinforcement of disease-oriented rather than patient-oriented medicine is caused by limitation on time and the high level activity of tasks like record-keeping, procedures, work rounds, and so on.

PSYCHIATRY'S ROLE IN MEDICAL EDUCATION

It was the recognition of such deficiencies in training on

acute medicine wards that made the introduction of psychiatry into the general hospital so enthusiastically welcomed.

Although liaison psychiatry was considered by Greenhill[1] an outgrowth of the psychosomatic movement begun in Austria and Germany in the early decades of this century, an article in the American Journal of Psychiatry in 1929 general marks the introduction of psychiatry into general hospitals in the United States. The publication of Henry's[2] paper "Some Modern Aspects of Psychiatry in General Hospital Practice" was an historical landmark for psychiatry's educational role in medical education in the general hospital setting. It was hailed as a beginning of new opportunities to include an appreciation of psychosocial variables in medical care and training.

From this time in the early 30's through the 60's, the history of such efforts at bridge-building has been well-documented by Greenhill,[1] Lipowski,[3] Wittkower,[4] and others. Greenhill points out that the development of the term "liaison psychiatry" as opposed to, for example, liaison medicine, resulted from the fact that initiatives for promoting a more comprehensive medical model came largely from psychiatry and it is probably the expression of such initiative which caused some psychiatrists to be branded missionary in their zeal to teach.

NIMH

Nonetheless, some significant progress was made in the inclusion of psychiatry in the general hospital through support from the Rockefeller Foundation, the Commonwealth Fund, the U.S. Public Health Service and the National Institute of Mental Health. Although studies were not performed to assess the impact of the new programs, there was a strong sense that programs like Kaufman's[5] at Mount Sinai Hospital, Bibring's[6] at Beth Israel Hospital in Boston, and Billings'[7] at Colorado Medical Center, had a clear influence on the way in which medicine was taught and practiced.

Amongst psychiatrist teachers there was a natural favorable bias, but some writers have emphasized the enduring obstacles to bridge-building in the sometimes alien lands of other medical specialities.

INPATIENT PSYCHIATRIC UNITS

The next big landmark for a more expansive presence of psychiatry in the general hospital was the establishment of inpatient psychiatric units.[8] This too had small beginnings early in the century but had its greatest growth spurt following World War II. Many psychiatrists returned from the war having learned that short-term psychiatric treatment was more effective than long-term custodial

approaches. In recent years, the process of deinstitutionalization has added strength to the trend to focus all psychiatric services in the community hospital. Some of the advantages are obvious: less stigma for the patient; maintenance of family and community connections; more active treatment programs; and greater accessibility to the entire spectrum of health facilities and treatment.

In spite of such progress, opportunities for the teaching of a more integrated and accepted mental health program have been less real than apparent. Hospital administrators generally located psychiatry at some distance from the rest of the clinical activities of the hospital; psychiatric units were compartmentalized from medicine, with little exchange of interaction with other departments; familiar biases and resistances, often contributed to by psychiatrists themselves, hampered a truly collaborative experience with departments of medicine.

The recent trend toward development of med-psych units offers opportunities to correct some problems, but it is premature to judge their success. Although one must hope that the intermingling of psychiatric and nonpsychiatric staff is mutually educational, surveys to date of the psychiatric skills and knowledge of nonpsychiatrists have not been encouraging.

PRIMARY CARE MOVEMENT

With less than optimal pedagogic achievements through consultation-liaison programs and then general hospital psychiatry units, the primary care movement begun in the late 60's and mandated into public law in 1976[9] held, for some, a promise of greater opportunity for achievement of a biopsychosocial model of health and illness which would evolve from a closer marriage of medicine and psychiatry, the biomedical and the psychosocial. Recent years have seen a great proliferation of primary care curricula and family practice residencies, although the success of the marriage has been less than optimal.

Still, there are programs which did not exist before. And, although the literature for decades has reported the numbers of patients who present to general physicians with complaints caused by emotional problems, the focus on primary care medicine has nurtured an enormous increase in such studies. Many formal organizations have taken as their task the study of primary medical care. The National Institute of Mental Health[10] produced in 1979 an analytical review of the literature on mental disorders and primary medical care. This review was largely contributed to by the Psychiatric Sociology Division of the Society for the Study of Social Problems.

The American Psychiatric Association, the American Sociological Association, the Association for Academic Psychiatry, the Society for Research and Education in Primary Care Internal Medicine, the American Academy of Family Practice and many others have devoted abundant time, energy, staff and money in the service of studying and promoting primary care concepts. Similar, if less extensive, efforts have occurred in England, Japan, Israel, Italy, West Germany, and other countries.

The medium for most efforts in psychiatric training of nonpsychiatric primary physicians is consultation-liaison psychiatry or psychosomatic medicine. While most of this training occurs in medical centers, through inpatient and outpatient work, some experience has been reported with neighborhood health centers, community agencies, and mobile health units.

CONTROVERSY AND IMPEDIMENTS

So it can be seen that, by this time, there has been a vast experience in the general hospital setting, with efforts at achieving an integrated biopsychosocial health care model. Yet the success of such programs is less than desired and we have still not had sufficient methodologically-controlled studies to say what our achievement has been. Reports have appeared which describe, on the one hand, the general hospital as a fertile field[11] for both medical and psychiatric education, and on the other hand, question whether the medical setting is beyond the general psychiatrist's competence[12] so that he fails as a collaborator, colleague and teacher of nonpsychiatrist physicians.

There are also rapid changes in hospital structure and function which stand, at times, in opposition to the kind of training which might nourish psychological-mindedness in medical students and house officers.[13] New technology and procedures, increased demands upon house staff, and a new kind of industrial-market-place model of medical care seem to threaten long-standing traditional values considered essential to good doctor-patient relationships. Some writers have questioned whether appropriate holistic training can occur in such settings where the technologic (and now economic) imperative competes with the humanistic requirements of whole-person health care. I am reminded of Winnicott's[14] remark in writing of the barriers to an integrated approach to psyche and soma, that the separation is "...a defense organization with very powerful determinants, and for this reason it is very common for well-meaning and well-informed and even exceptionally well-equipped doctors to fail in their efforts to cure patients with psychosomatic disorder." This inherent resistance to a joining of forces undoubtedly exists as much for physicians as it does for patients and raises serious questions about how much can be

achieved without major modification of medical school admission requirements, medical faculty, institutional structure, and attitudinal bias.

CONCLUSION

In spite of a number of impediments, I would still hold that the general hospital, with a fuller accommodation of psychiatric facilities, services and educational programs, is a better setting for biopsychosocial education than we have previously known. It has been in the general hospital that a large body of knowledge about the psychological impact of illness and hospitalization has been learned. Every new surgical and medical advance, such as open heart procedures, transplant surgery, new special care units (ICU, CCU, PCCU, Hemodialysis, Burn, Oncology), etc., has brought with it new demands for concomitant emotional understanding and care. If the psychiatrist can learn to incorporate such new experience into the matrix of his medical education, there is hope that he can also transfer such learning into the context of primary care education.

Perhaps because the close scrutiny of psychiatric programs for non-psychiatrists has exposed major gaps, there is some tendency toward discouragement and pessimism. But if we see such evidence as a challenge for innovation and creativity, new approaches to research and teaching have the potential for fostering a closer approximation to the idealized model of health care for the future, with the general hospital serving as a kind of university for education in medical practice.

REFERENCES

1. M.H. Greenhill, The development of liaison programs, in: Psychiatric Medicine, G. Usdin, ed., Brunner/Mazel, New York (1977).
2. G.W. Henry, Some modern aspects of psychiatry in general hospital practice, Amer J Psychiat 86:481-499 (1929).
3. Z.J. Lipowski, Consultation-liaison psychiatry: an overview, Amer J Psychiat 131:623-629 (1974).
4. E.D. Wittkower, J.M. Cleghorn, Z.J. Lipowski, G. Peterfy, L. Solyom, A global survey of psychosomatic medicine, Int J Psychiat 7:499-516 (1969).
5. M.R. Kaufman, The role of the psychiatrist in a general hospital, Psychiat Quart 27:367-381 (1953).
6. G.L. Bibring, Psychiatry and medical practice in a general hospital, The New Eng J Med 254:366-372 (1956).
7. E.G. Billings, The psychiatric liaison department of the University of Colorado Medical School and Hospital, Amer J Psychiat 122:28-33 (1966).

8. M.H. Greenhill, Psychiatric units in general hospitals: 1979, Hosp Comm Psychiat 30:169-182 (1979).
9. P.L. 94-484. The Health Professions Educational Assistance Act of 1976. U.S. Congress.
10. National Institute of Mental Health, Series D, No. 5, Mental Disorder and Primary Medical Care: An Analytical Review of the Literature. DHEW Publ. No. (ADM) 78-661, Supt. of Documents, U.S. Govt. Printing Office, Washington, DC 20402 (1979).
11. T.H. Wise, The general hospital: fertile ground for psychiatric education, (unpublished manuscript).
12. J.J. Strain, The medical setting: Is it beyond the psychiatrist? Amer J Psychiat 134:253-256 (1977).
13. D.R. Lipsitt, Some problems in the teaching of psychosomatic medicine, in: Psychosomatic Medicine: Current Trends and Clinical Applications, Z.J. Lipowski, D.R. Lipsitt, P.L. Whybrow, eds., Oxford, New York (1977).
14. D.W. Winnicott, Psycho-somatic illness in its positive and negative aspects, Int J Psycho-anal 47:510-516 (1966).

PSYCHIATRIC CONSULTATIONS IN THE ELDERLY IN A GERIATRIC AND A TEACHING HOSPITAL: IMPLICATIONS FOR PSYCHIATRIC TEACHING AND TRAINING

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SUMMARY

A series of 92 consecutive referrals for psychiatric opinion made over a fifteen month period from a geriatric hospital was retrospectively examined in order to ascertain the nature of the advice which the geriatricians requested from psychiatrists. These are compared with a series of 41 consecutive referrals over the same period from a large teaching hospital in the same city, these referrals coming from general physicians, urologists, orthopaedic surgeons and genito-urinary surgeons. In the geriatric hospital, assessment and treatment of the depression was the commonest reason for referrals followed by advice on continuing care placement and assessment of confusion. By contrast the commonest reason for referral in the teaching hospital was advice on longstay placement followed by assessment of confused behaviour. In the geriatric hospital group the three commonest diagnoses made by the referrer were: depressive illness, senile dementia and confusional states; the psychiatrists made this last diagnosis much more frequently than the geriatricians. In the teaching hospital group the two most frequent diagnoses made by the referring doctors were dementia and "confusion" used in an unspecified way. In the geriatric hospital acute confusional states were referred much less frequently than in the general hospital. The proportion of patients seen in the teaching hospital with multi-infarct dementia was much greater than in the geriatric hospital. The implications for the appropriate training of psychiatrists and referring doctors in this aspect of liaison psychiatry are discussed as a result of these findings and of a survey conducted prior to the 1982 Cambridge Conference on Recruitment and Training in Psychiatry.

Introduction

In the United Kingdom, the proportion ofover 65s in the population, has probably attained its liekly peak at 15% but in the next twenty years the number of the very old - over 80s - will increase by about 40%. Most of this group will be women without husbands, living alone and with a high rate of mental illness and social problems.[1] As more old people with psychiatric disorders are likely to be admitted both to geriatric and general hospitals doctors working there will need to be more knowledgeable and skilled in understanding and managing the problems they present while psychiatrists who will be called upon for opinion will also need more expertise.

We would like to give our experience with ward referrals of over 65s in a geriatric hospital - Chesterton - and a teaching hospital - Addenbrooke's - both situated in Cambridge.

As psychogeriatrician to the Cambridge District P.B. sees the great majority of over 65 ward referrals from Addenbrooke's; Dr Harris, then a research senior registrar, took on the main responsibility for ward referrals from Chesterton over a period of fifteen months. We have looked at these referrals for this period to find out reasons for referrals, what diagnoses were made, the outcome, the association between psychiatric disorder and physical problems and compared the nature of the referrals from the two types of hospitals.

Method

All psychiatric referrals from Chesterton and all referrals over 65 from Addenbrooke's were retrospectively examined over the fifteen month period while Dr Harris was in post in order to determine the main reason for referrals and psychiatric diagnosis made by the referring physicians or surgeons, the main psychiatric diagnosis made by the psychiatrist was then noted. The case notes were looked at to determine the actual physical problems at the time of the referral, the length of the pateint's stay in hospital and the outcome of that stay together with the cause of death if appropriate.

Results

90 of the 92 referrals from the geriatric hospital requested advice on short stay patients while all 41 of the teaching hospital referrals were short stay. The age and sex of the patients by hospital and diagnosis for the geriatric hospital are set out in Table 1.

Reasons for Referral

The three commonest reasons for referral which between them covered nearly half of the total were, first advice on the

TABLE 1. Age and Sex of Referrals

	No.	Ratio F/M	Age (years) Mean	Range
Geriatric Hospital - total	90	3/1	79.6	65-99
Depressive illness	29	2/1	77.3	65-90
Acute Confusional state	29	2/1	82.2	73-92
Senile dementia	19	3/1	84.0	65-99
General Hospital total	41	2.5/1	76.7	62-90

assessment and treatment of depression, second advice on placement and third advice on the management of confusion. Advice on bheavioural problems follow closely in frequency but there were fewer cases in each category of the other 19 reasons for referral. Patients with depression being referred much more frequently from the geriatric hospital (geriatric = 17%, Teaching = 10%) but with advice on longstay placement (Geriatric 14%, Teaching 29%) and assessment of confusion (Geriatric 13%, Teaching 27%) markedly predominating in referrals from the teaching hospital.

Psychiatric Diagnosis

Turning to the diagnoses made by the psychiatrists it will be seen from Table 2 that depressive illness, acute confusional state and senile dementia account for more than four fifths of the referrals. Other daignoses such as anxiety states, personality disorder, paraphrenia and hypomania are uncommmon. However with the teaching hospital referrals there were fewer cases of depression and acute confusional state but more cases of dementia compared with the geriatric hospital.

TABLE 2. Psychiatric Diagnosis in Geriatric Referrals

	Geriatric n=90%		Teaching n=41%	
Depressive illness	32		22	
Acute confusional state	32		12	
Dementia - senile	21)	55)	54)	66
Dementia - multi-infarct	2)		)	
Anxiety state	2			
Personality disorder	2			
Normal	3			

Single cases of symptomatic dementia, hypomania, Korsakoff State & paraphrenia

Diagnosis of Referring Physicians

The referring geriatricians made a psychiatric diagnosis in 65 of the 90 referrals; most commonly this was depressive illness and the psychiatrist agreed in two-thirds. A quarter of the geriatricians cases were diagnosed by them as having senile dementia and the psychiatrists agreed again in two thirds. In only 6 cases, that is fewer than 10%, was the diagnosis of an acute confusional state made with the psychiatrist agreeing in all cases. The pattern however was different in the teaching hospital referrals. There was close agreement between physician and psychiatrist in the diagnosis of dementia whether Alzheimer, mixed or unspecified, but the psychiatrist diagnosed six cases of multi-infarct dementia to the physicians three. There was good agreement about patients with acute confusional states but the physicians used a loose term "confusion" which clearly wasnot being used in a strict diagnostic sense but as a description of behaviour generally due to dementia. They psychiatrists diagnosed depression in nine cases - only four of whom had been so identified by the physician.

Outcome

Patients with depressive illness and acute confusional states were discharged home (55% and 53% respectively) while 63% of those with senile dementia were transferred to continuing care wards or old peoples homes with 23% going back to their own homes. The death rate amongst the depressive illness patients was 21% compared with 18% for those with acute confusional states and 14% of those with senile dementia.

Physical Problems

The commonest physical problems are shown in Table 3. No active problems were seen in 9% of the sample, mainly those with depression and senile dementia. Recovery from fractured femur was especially prominent in the organic group while cerebral vascular accident and respiratory infection were equally represented between the functional and organic groups. Immobility as a physical problem was found only in the depressive group and was confined to those in the geriatric hospital.

Discussion

The relative proportions of psychiatric diagnoses in the teaching hospital referrals are almost identical to those found by Krakowski[2] in hospital referrals in northern New York. The three main diagnoses, depressive illness, dementia and acute confusional state are also found in the geriatric hospital referrals in our study. The geriatric staff sent us on fewer cases with dementia and more with acute confusional state. This remained statistically significant even when those acute confusional states

TABLE 3. Associated Physical Problems

	Depressive Illness	Acute Confusional State	Senile Dementia
	n=36	n= 35	n = 37
Hypothermia	0	0	3
Cerebrovascular accident	5	4	5
Immobility	4	0	0
Extrapyramidal syndromes	3	2	1
Respiratory Infection	2	3	2
Congestive cardiac failure	1	5	4
Fractured femur	1	6	7
Other surgical	3	3	5
Nil	5	1	4

occurring on a background of dementia were re-classified as being demented. We feel that this difference might reflect differences in the diagnostic viewpoint of the geriatric and teaching hospital psychiatrists or a real difference in the relative rates of the referral of these conditions. The former hypothesis seems unlikely, the authors worked closely together and used diagnoses in a similar way, so we think it is very possible that the geriatricians who are well experienced in the diagnosis and management of dementia did not feel it necessary to seek psychiatric advice in this group. The increase in the proportion of acute confusional states referred might reflect an admission bias of the two hospitals so that those with confusion as well as physical illness might be referred to the geriatric hospital while those with physical and little or no confusion might go to the teaching one.

Outcome of the geriatric referrals is in the main understandable. The high death rate in the patients with depressive illness is also understandable as referrals are from a population of actuely sick people but we would again emphasise that in the depressive illness group immobility was a recurrent physical problem and four of the seven deaths were attributable to pulmonary embolism and deep vein thrombosis.

Frequency with which assessment of confusion was a reason for referral and the infrequencvy with which the geriatric hospital physicians used the specific term "acute confusional state" is striking. It might be that they equate the two terms but if they do then clearly the psychiatrists do not agree as they made a diagnosis of acute confusional state in 58% and dementia in 42%. Professor Tom Arie has recently commented on the lack of understanding of confusion and wondered if "the intimation of decay in a fellow creature makes the contemplation of a confused individual unattractive and even frightening".[3] We feel it is highly important to ensure that all doctors can distinguish acuteconfusional state from dementia and if there has been neglect of delirium and

if the concept of confusion is frightening then these are matters to be attended to in medical training.

Because of the changing age structure of the population it is certain that elderly patients with concomitant mental disorder will enter general hospital and geriatric beds at an increasing rate. All psychiatrists - not just psychogeriatricians - must be adequately trained to give appropriate advice on this aspect of liaison work. however in the United Kingdom training and experience in all aspects of liaison work - geriatric and non-geriatric both at undergraduate and post-graduate level remains patchy.

To illustrate this point it seems appropriate to mention briefly a survey of 25 teaching hospitals in England and Wales undertaken by Dr. Christ Thomas of the Department of Psychiatry University of Leicester as part of the preparatory work for the 1982 Cambridge Conference on Recruitment and Training in Psychiatry.[4]

The schools were first asked how often medical students saw and were taught on general hospital referrals: the results are given in Table 4. If self poisoning cases are omitted about half the medical schools provide almost no practical experience in liaison psychiatry, while lectures and seminars are equally scanty. Schools were also asked if there was liaison teaching involving psychiatrists on general firms; four (19%) replied often, four (19%) occasionally, seven (33%) rarely and six (29%) never. Dr Thomas also made enquiries of 82 post-graduate training schemes asking about liaison experience and obtained a 63% response.

It will be seen from Table 5 that although most trainees get at least occasional experience of self-poisoning, a third get almost no casualty experience and nearly a half have little chance of seeing general ward referrals. Fifteen of the schemes had a specific consultation liaison post as part of their rotational training scheme but the remaining 37 had no such attachment. However, many trainees do pick up the experience particularly in the senior registrar grade and by the time that they become consultants 60% of recently appointed consultants reported in a survey (Brook N.P.) that they had received adequate experience which was adequately supervised in this field.

Dr Thomas's survey did give good evidence that students' attitudes to psychiatry showed a marked improvement after the clerkship in those schemes providing better than average experience in liaison work while in two schools providing average experience only there was no real change in attitudes during this period as shown in Table 6. Although it would be dangerous to read too much into this study because of other factors apart from liaison experience having an effect there is we believe a prima facie case that this type of work has potential to improve recruitment to our specialty and we should do all we can to encourage the development of liaison psychiatry.

TABLE 4. Number of Medical Schools Providing Liaison Experience

	Often	Occasionally	Rarely	Never
Self-poisoning referrals	3 (14%)	10 (48%)	6 (29%)	2 (10%)
Casualty referrals		9 (43%)	6 (29%)	6 (29%)
Other ward referrals		12 (57%)	6 (29%)	3 (14%)

TABLE 5. Number of Training Schemes Providing Liaison Experience

	Often	Occasionally	Rarely	Never
Self poisoning referrals	23 (44%)	25 (48%)	3 (29%)	1 (2%)
Casualty referrals	7 (13%)	28 (54%)	10 (19%)	7 (13%)
Other ward referrals	2 (4%)	26 (50%)	20 (38%)	4 (8%)

TABLE 6. Medical Students' Attitudes to Psychiatry in Relation to Adequacy of Liaison Experience

Medical School	N	Before	After	
		Above Average Liaison Psychiatry Teaching		
(1) A	17	97.6	107.3	+ 9.7
B	16	92.8	107.2	+ 14.4
(2)	14	100.2	109.6	+ 9.4
(3)	11	95.4	115.2	+ 19.8
		Average Liaison Psychiatry Teaching		
(4)	11	93.8	93.4	- 0.4
(5)	12	99.8	100.8	+ 1.0

REFERENCES

1. Arie T. and Isaacs A.D. In: Studies in Geriatric Psychiatry p. 241 Wiley. Chichester and New York (1978)
2. Krakowski A.J. Biblthca. Psychiat. No. 159 163-6185 (1979)
3. Arie T. Age and Ageing 7. Supplement p. 72 (1978)
4. Walton H. Preliminary papers on the Conference on Recruitment and Training in Psychiatry. 'Liaison Psychiatry' C. Thomas. (Privately Printed) (1982).

POINT PREVALENCE OF PSYCHIATRIC AND PSYCHOLOGICAL DISORDERS IN THE GENERAL HOSPITALS OF MADRID (PRELIMINARY RESULTS)

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The association of psychiatric symptoms and especially neurotic disorders, with episodes of physical illness, has been repeatedly studied and verified in different ways. These studies have ranged from investigations on general population (Hinkle and Wolff, 1958; Hinkle et al., 1958; Rawnsley and Loudon, 1964; Hagnell, 1966; Gillis et al., 1968; Vázquez et al., 1981) and samples of general practice (Sheperd et al., 1966; Kreitman et al., 1966; Goldberg and Blackwell, 1970; Eastwood and Trevelyan, 1972) to studies of psychiatric inpatients and outpatients (Davies, 1965; Maguire and Granville-Grossman, 1968).

The figures for psychiatric morbidity in patients admitted to general hospitals also tend to highlight this relation, since they are higher than those normally obtained for the general population. Santo Domingo (1974) stydying the patients admitted to a medical service, obtained a prevalence of 75%. Some of us have found a rate of 72.5% in medical patients (Muñoz and Crespo, 1980). Medina-Miro et al. (1983) obtained a psychiatric morbidity rate of 47.15% in a sample of internal medicine, general surgery and gynecology patients.

Furthermore, in the review made by Greenhill (1977), prevalence figures of 15 to 72.5% were reported. These figures ranged from 20 to 70% in a later study by Lipowski (1979). These differences are not only influenced by the use of patient samples from different hospital services, but also by variations in the case definition used.

Our investigation, from which these are preliminary results,

has the purpose of providing facts on the psychiatric morbidity in patients admitted to the different general hospital services, using standardized measuring instruments.

Thus, for our study we have used a broad sample of the patients admitted to all the general hospitals serving the population of Madrid so that not only the different medical and surgical services are represented, but also different population subgroups.

As the measure of psychiatric morbidity, prevalence-day was determined by the 60-item version of the General Health Questionnaire (Goldberg, 1972). This version has been adapted and validated to Spanish language by one of us on a general practice sample (Muñoz et at., 1978). The results obtained for sensitivity, specificity and misclassification rate are acceptable and similar to those obtained in validations of the original version (Goldberg and Blackwell, 1970); Benjamín et al., 1982).

METHODS

The sample comprises a total of 1,494 patients systematically selected - one of every three - from among the admitted population between the ages of 15 and 65, on 15 November 1982, to eight general hospitals in Madrid (C.E. Ramón y Cajal, C.S. La Paz, C.S. 1º de Octubre, Clínica Puerta de Hierro, Hospital Clínico, Gran Hospital, Fundación Jiménez Díaz and Hospital Provincial). Before starting, all those patients were excluded who were admitted to services which, by their nature, implied physical conditions incompatible with the administration of the questionnaire. The patients admitted to obstretrics services were also excluded. 58% of the total patients selected belonged to medical services and 42% to surgical services.

The sample was reduced, for different reasons, to a total of 1,322 patients, of which 555 belonged to medical services (42%) and 777 to surgical services (58%), with almost 50-50% distribution by sex. Table I gives the sociodemographic characteristics of the sample investigated.

Personal data, clinical data (diagnosis (CIE-9), psychosocial stressors (adapted from DSM III), acute or chronic nature of the illness) and medical care data (time of stay, reason for admittance, initiative of admittance, etc.) were collected for all the patients and they were given the 60-item GHQ.

A cut-off point between 9 and 10 was considered for the calculation of the probable prevalence, applying the formula proposed by Goldberg (Goldberg et al., 1976; Goldberg, 1981) according to the criteria for screening tests derived by Meehl and Rosen (1955) from Bayes' theorem.

Table I. Sociodemographic Characteristics of the Sample Investigated

	N	%		N	%
SEX			MARITAL STATUS		
Male	677	51	Single	284	21
Female	655	49	Married	939	70
			Widows	93	7
AGE			Separated/divorced	15	1
15 - 24	141	10.5			
25 - 34	153	11.5	SOCIAL CLASS		
35 - 44	209	16	I and II	76	6
45 - 54	349	26	III	445	33
55 - 65	471	35	IV	505	38
			V	299	22

$$\text{Probable prevalence} = \frac{\%\text{ with high scores} - \%\text{ false positives}}{\text{sensitivity} - \%\text{ false positives}}$$

For application, we used a sensitivity of 86.2% and a false positive rate of 13.8%, having obtained these figures in the Spanish validation on general practice population (Muñoz et al., 1978).

The information obtained was processed by the SPSS statistical package, and to detect the interaction effects between variables, we used the tree analysis of Sonquist, Ba and Morgan (1974), by a specific computer program.

RESULTS

1. Prevalence values

The probable prevalence for the total sample is 62%. Its distribution by hospitals ranges from a maximum 71% at the Fundación Jiménez Díaz to a minimum 54% at the Gran Hospital.

For men it is 53% and for women 71%.The age group of 45 to 54 presents the highest prevalence (74%), the lowest values (44%) being for the 15 to 24-year group. These figures are found for both sexes. The distribution of morbidity according to the variables in which it acquires statistical significance is given in Table II.

2. Morbidity-related Factors

Studying the statistical independence between scores above and below the cut-off point (9/10) and the independent variables,

Table II. Distribution of Prevalence Values (%) according to the Variables in which it acquires Statistical Significance

	%		%
SEX		ADMITTANCE INITIATIVE	
Male	53	Own	67
Female	71	Referral	58
AGE		INPATIENT	
15 - 24	44	Medical	71
25 - 34	54	Surgical	56
35 - 44	59		
45 - 54	74	PREVIOUS PSYCHIATRIC TREATMENT	
55 - 65	62	Yes	83
		No	58
COHABITATION			
Alone	51	SERVICE	
Family of origin	53	Endocrinology	89
Own family	62	Rheumatology	79
Friends/relatives	82	Cardiology	73
		Internal Medicine	71
SOCIAL CLASS		Neurology	68
I	37	Pneumology	65
II	42	Digestive Surgery	64
III	58	General Surgery	63
IV	61	Nephrology	60
V	74	Traumatology	57
		Gynecology	55.5
EDUCATIONAL LEVEL		Otorhinolaryngology	55.5
Illiterate	75	Gastroenterology	53
Primary	62	Urology	50
Lower Secondary	54	Maxillofacial Surgery	46
Upper Secondary	57	Dermatology	43
University	52	Rehabilitation	31
		Vascular Surgery	25

we found the following related factors.

a) Psychosocial stressors. (x^2 = 72.01, 1 d.f. $p < 0.01$). Those of severe and extreme degree are over-represented. This is the variable which has the most statistical significance and maintains itself in all the subgroups of the sample.
b) Previous psychiatric treatment. (x^2 = 21.21, 1 d.f. $p < 0.01$). The patients which had received previous treatment are over--represented.
c) Sex. (x^2 = 23.23, 1 d.f. $p < 0.01$). Women over-represented.
d) Patients (medical or surgical). (x^2 = 15.50, 1 d.f. $p < 0.01$). Medical patients over-represented.

e) Age. (x^2 = 24.43, 4 d.f. $p < 0.01$). The patients of the 45-54 years group are over-represented.
f) Cohabitation type. (x^2 = 12.64, 4 d.f. $p < 0.01$). Patients who live alone and with friends and/or relatives are over-represented.
g) Social class. (x^2 = 18.19, 4 d.f. $p < 0.01$). Patients of level V are over-represented.
h) Educational level. (x^2 = 9.89, 4 d.f. $p < 0.05$). Illiterates are over-represented.
i) Occupation. (x^2 = 21.16, 8 d.f. $p < 0.01$). Patients of liberal professions and self-employed workers are over-represented.
j) Admittance initiative. (x^2 = 4.45, 2 d.f. $p < 0.05$). Patients admitted on their own initiative are over-represented.

Factors which are not of statistical significance are: the hospital, marital status, residence and employment situation.

3. Psychiatric Risk Factors

For the analysis of the interaction between variables related to the risk of becoming a probable psychiatric patient (score in the GHQ above or below the cut-off point), we have used the segm entation analysis technique, previously mentioned (Sonquist, Baker and Morgan, 1974). The following variables were used for the analysis: sex, age, marital status, residence, social class, patients (medical or surgical), somatic diagnosis, presence of psychosocial stressors, previous psychiatric treatment and amittance initiative. Only psychosocial stressors, somatic diagnosis, previous psychiatric treatment, sex, age and social class took part in the succession of dichotomies.

The two groups in which the probability of being a case was 100% have the following characteristics:

a) Presence of severe and extreme psychosocial stressors, a diagnosis which is no tumor, infection, traumatism or disease of the genitourinary tract, female sex and age of 45 to 54. This group represents 3.3% of the total sample.

b) Presence of severe and extreme stressors, female sex, diagnosis of the nervous system, respiratory tract, skin, osteomuscular system, puerperium complications or some congenital abnormality, and age between 15 and 44 years or over 55. This group represents 1.8% of the total.

Another group in which there is a high probability - 77% - of being a case is composed of patients who have previously received psychiatric treatment and who present a moderate stressors. This group represents 4.83% of the total.

The group in which the probability of being a case is the lowest - 25% - comprises the patients with moderate or none stressors, who have not received previous psychiatric treatment and belong to social class I and II. This group represents 4.17% of the total sample.

Moreover, it should be pointed out that the presence or absence of psychosocial stressors is the discriminating factor on the first level. The somatic diagnosis and previous psychiatric treatment are on a second level.

DISCUSSION

The prevalence figures found are situated within the limits reported in the reviews of Greenhill (1977) and Lipowski (1979) and they correspond with the figures which two of us previously found in a hospital outside of Madrid (Muñoz and Crespo, 1979, 1980) by similar methods. These figures also concur with those found in medical patients at the C.S. La Paz (Santo Domingo et al., 1974) by a clinical interview technique.

The comparison of these probable prevalence figures with those generally admitted for the general population (Dohrenwend et al., 1980) shows them to be clearly higher, irrespective of the patient identification technique used. This fact once again confirms the hypothesis of a relation between physical and psychiatric pathology.

Furthermore, the preliminary results point to certain factors as condicionants of the risk of suffering a psychiatric disorder. The presence of psychosocial stressors stands out in particular, as has been amply reported in literature. A more detailed analysis of these factors will permit more precise conclusions to be reached.

REFERENCE

Benjamin, S., Decalmer, P. and Heran, D. (1982). Br.J.Psychiatry, 140, 174-180.

Davies, D.W. (1965). Br.J.Psychiatry, 111, 27-33.

Dohrenwend, B.P. et al. (1980). Mental Illness in the United States. Epidemilogical Estimates. N.Y. Proeger Publishers.

Eastwood, M.R. and Trevelyan, M.H. (1972). Psychological Med., 2, 363-372.

Gillis, L.S., Lewis, J.B. and Slabbert, M. (1968). Br. J. Psychiatry, 114, 1575-1587.

Goldberg, D.P. (1972). "The Detection of Psychiatric Illness by Questionnaire". London, Oxford University Press.

Goldberg, D. (1981). In What is a Case?, J.K. Wing, P. Bebbington and L.N. Robins (eds.). London, Grant McIntyre.

Goldberg, D. and Blackwell, B. (1970). Br. Med. J., 2, 439-443.
Goldberg, D., Kay, C. and Thompson, L. (1976). Psychological Med. 6,565-569.
Greenhill, M.H. (1977). In Psychiatric Medicine, G. Usdin, ed. Brunner-Mazel, New York.
Hagnell, O. (1966). A Prospective Study of the Incidence of Mental Disorder. Lund, Snenska Bokforlaget Norstedts.
Hinkle, L.E. Jr. and Wolff, H.G. (1958). Am. Internal Med., 49, 1373-1380.
Hinkle, L.R. Jr., Christenson W.N., Kane, F.D., Ostfeld, A., — Thetford, W.N. and Wolff H.G. (1958). Psychosomatic Med., 20, 278-295.
Kreitman, N., Pearce, K.J. and Ryle, A. (1966). Br. J. Psychiatry 112, 569-579.
Lipowski, Z.J. (1979). Psychiatria Fennica, 32-57.
Maguire, G.P. and Granville-Grossman, K.L. (1969). Br. J. Psychiatry, 115, 1365-1369.
Medina-Mora, M.E., Padilla, G.P., Campillo-Serrano, C., Mas, C.C. Ezban, M., Caraveo, J., and Corona J. (1983). Psychological Med., 13, 355-361.
Meehl and A. Rosen. (1955). Psychological Bull., 52,194-216.
Muñoz, P.E. y Crespo M.D. (1979). Rev. Psiquiatría Psicología - Méd., 13, 481-502.
Muñoz, P.E. y Crespo, M.D. (1980). Actas Luso-Esp. Neur. Psiquiatría, 4, 299-310.
Muñoz, P.E.; Vázquez, J.L. et al. (1978). Social Psychiatry, 13, 99-104.
Rawnsley, K. and Loudon, J.B. (1964). Br. J. Psychiatry, 110, - 830-839.
Santo-Domingo, J., Carrasco J.J., Alonso A. y Calvo R. (1974). Med. Clínica, 63, 174-184.
Shepherd, M., Cooper, B., Brown, A.C., Kelton, G.W. (1966). Psychiatric illness in general practice. London, Oxford University Press.
Sonquist, J.A., Baker, E.L. and Morgan, J.N. (1974). Searching for Structure. Ann Arbor, Michigan, Institute for Social - Research.
Vázquez, J.L., Muñoz P.E. and Madoz, V. (1981). Br. J. Psychiatry, 139, 328-335.

DEATH DUE TO SUICIDE IN MEDICAL AND SURGICAL WARDS

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The suicide of patients admitted to non-psychiatric wards of general hospitals is a relatively frequent happening. In the majority of these type of statistics, the amount of this type of fatality is superior to those occurring in psychiatric institutions. This is explained not only because the hospitalization brings with it a threat to the person's health, but also because of loneliness due to the seperation from customary environment and family. Many times, the hospital staff is not able to substitute or at least compensate the need for affection and emotional stability of the patient, giving more attention to his physical well-being rather than the psychological one.

When a patient admitted to a general hospital dies by suicide, very important reactions are produced throughout the hospital. Administration fears the possible demands for malpractice or negligence. The health staff feels guilty and criticism of previous actions are produced. The patients realize their defencelessness and bring forth own ideas of death. These attitudes, although intense, are not of long duration and soon give way to justification, forgetfullness or negation. Nevertheless, sometimes the intervention of the Psychiatric Service is requested in these cases, so that this Service can propose preventive measures and possible solutions. In order to gather some information of the problem, which would permit evaluating its entirety and identify the most vulnerable subjects, the authors have carried out this study and previous ones (Saiz-Ruiz et al. 1983) in their respective hospitals.

Both hospitals, C.S. Primero de Octubre (C.S.P.O.) and Centro Ramón y Cajal (C.R.C.) are of a national scope and provide some 1,400 beds and 18,000 admissions per year. The C.S.P.O. takes care of a periphery of a working class area of a the southern zone of Madrid, with a large amount of young families emigrated from other parts of the nation. The Psychiatric Service attending to consultations is not provided with hospital beds. The C.R.C. does have a unit of 27 beds for psychiatric hospitalization, with an open character. In this hospital there exists an over - representation of surgical beds because of its being a Center highly specialized in this field. We have studied retrospectively all the suicide cases occurring from January of 1978 to June of 1983. The investigation was carried out through facts obtained in clinical and judicial documents, with a semi-structured interview with those responsible for the case. It is important to point out that the acquisition of these facts was a painstaking task, because of the reluctant and hostile attitude of the personnel involved as well as the "misplacement" of some documents which were finally obtained.

Table 1 summarizes the principal characteristics of the sample, the 17 cases organized according to age. Nine of them were married, six were single and two widowed. In our areas the predominence of the masculine sex is not as clear as in other studies (Pollak and Missliwetz, 1979; Ripley, 1979) although we can observe an accumulation of males in the higher age groups. With respect to the diagnoses, we can group them as follows: two patients were mental patients who had been admitted for observation or treatment to the C.S.P.O, which lacks a psychiatric unit. One of them was admitted for a suicide attempt by intake of drugs, which was only discovered later on and produced aspirational pneumonia. It has already been pointed out how these patients admitted for suicide attempts are a risk 40 times greater of commiting suicide in the hospital (Glickman, 1980). Another two were admitted with symptoms not justified organically and the situation was analogous to that of the two previous ones. Six patients suffered serious illnesses with much suffering and of fatal prognosis. Of these, two suffered cirrhosis, two were terminal cancer victims, one has sclerosis and another a hematological illness. The rest of the sample presented complaints apparently treatable and in many cases with a minimum of repercussions. A significant fact is the frequent implication of surgical decisions; six of the cases had been operated and two more had refused this possibility. In three of them the suicide had taken place in the immediate post-operative period. In two other cases isolation was indicated because of the risk of infection and this also seemed to favor the suicide.

Concerning the length of stay at the hospital, it can be seen that seven cases died without completing a week's stay at the hospital. That makes us think that the first days following

Table 1: Characteristics of the sample

Age	Sex	Hospital	Length of stay(days)	Diagnoses
17	M	CRC	6	Cleft palate *
18	F	CRC	35	Mesenteric lymphadenitis *
23	F	CSPO	3	Schizophrenia
25	F	CSPO	3	Multiple sclerosis
35	F	CRC	68	Thrombotic purpura
35	F	CSPO	2	Functional disease
41	M	CSPO	3	Depression
52	M	CRC	1	Cirrhosis
53	M	CRC	33	Pulmonary tuberculosis
53	F	CRC	25	Disseminated carcinomatosis *
57	F	CSPO	26	Mitral stenosis
62	M	CSPO	77	Cirrhosis
66	M	CRC	14	Disseminated carcinomatosis *
66	M	CRC	18	Rectal carcinoma * *
69	F	CRC	37	Uterus prolapse *
70	M	CSPO	4	Prostatic hypertrophy
70	M	CRC	35	Anal fissure, diabetes

CRC=Centro Ramoń y Cajal
CSPO=Primero de Octubre
* operated previously

admission constitute the moments of major risk. In opposition to what was observed by other authors (Pollack, 1957), the psycho-organic syndromes and disturbances of conscience do not play a role in facilitating suicidal acts in our patients. Only in three of them were there previous episodes of confusion and we think that at the moment of carrying out the suicide this did not exist. The study of schedules, days and months in which the different cases were produced, does not offer any more information than that of their happening in the moments of less vigilance (change of shifts, for example). The means used for the suicide were in 16 cases throwing themselves out of the window, and the last one opened his oxygen tube and applied it to a catheter introduced in the subclavian vein. The differences among hospitals seemed to be explained by their particularities and the different groups of pupulation which they care for.

Without a doubt the most outstanding finding of this study is

that in none of the cases studied was a request for psychiatric consultation put through, a fact already encountered in previous studies (Shapiro and Waltzer, 1980). An easy explanation would be to consider that suicide in these patients responded to a quick and unforseeable impulse or was not associated with the existence of a psychiatric pathology. However, our data show in more than half the cases the existence of clues revealing a depressive depth, and even clear allusion to psychopathological symptoms. Therefore, our data supports the protective value that the psychiatric consultation exerts when confronted with the suicidal risk.

With the difficulties that a retrospective study creates, we have, however, found descriptions in several cases of situations where it has been clear the bad relationship and scant understanding between medical staff and patient. In the same way there has existed a limited sensibility to the calls for help (which seem directed more towards the nursing personnel than towards the medical staff) made by the patients.

There has been an emphasis recently (Bassuk, 1982) on the importance of recognizing those situations with a suicide risk, in order to proceed to its prevention. The case of the medical or surgical hospitalization seems to be a suitable model for it, since besides the loneliness and loss of physical health there are combined factors such as worthlessness and helplessness. The preventive measure would be in this case the psychiatric consultation carried out by the Psychiatric Service of the general hospital. To this Service also corresponds the task of improving the doctor-patient relationship and of sensitizing the hospital staff in the recognition and detection of the affective symptoms and those indicating the need for a psychiatric consultation.

REFERENCES

Bassuk, E.L., 1982, General Principles of Assesment. In: Lifelines: clinical perspectives in suicide. Plenum, New York.

Glickman, L.S., 1980, The Suicidal Patient. In:Psychiatric Consultation in the General Hospital. Marcel Dekker, New York

Pollack, S, 1957, Suicide in a General Hospital. In: Clues to Suicide, McGraw-Hill, New York.

Pollak, St. and J. Missliwetz, 1979, Selbsttötungen in Wiwner Krankenhäusern. Z. Rechsmed. 83, 233-244.

Ripley, H.S., 1079, Suicide in General Hospitals. West. J. Med.,130: 408-410.

Saiz-Ruiz, J., J.M. López-Ibor, F. Benitez Hita and F. Cañas de Paz, 1983, Suicide dans l'hôpital general. In: Depression et suicide: aspécts médicaux, psychologiques et socio-culturels. Pergamon, Paris.

Shapiro, S. and H. Waltzer, 1980, Successful Suicides and serious Attempts in a General Hospital Over a 15-year Period. Gen. Hosp. Psychiatry 2, 118-126.

THE TEAM APPROACH AND QUALITY OF CARE

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The quality of health care has been over the years, and still remains, a major preoccupation of the medical profession. The constant re-evaluations of the undergraduate programs in the medical schools, of the post-graduate programs for the different specialities and the development of Continuing Medical Education constitute some of the manifest examples of that concern. Psychiatry, as a medical speciality, has also made it a priority.

The broadening of psychiatric involvements since the last 30 years and the increased demande for care has lead to the development of the team concept borrowed from the Child Guidance Clinics henceforth applied on a larger scale to the field of psychiatric practice. The quality of interactions between psychiatrists and staff of various professional backgrounds, as it is also for those same professionals among themselves, is essential indeed to the good standards for the delivery of care of the patients.

A great deal of confusion has developed and still exists as to the basic training exigencies necessary to work in non-medical model situations like in school or social agencies, helping a client, vis-a-vis what is expected from a professional attached to a hospital-based psychiatric program, involved in the treatment of a patient. In the later case, the treatment will often be provided in a community clinic loosely affiliated to a hospital or functionning independantly.

Pressures to limit the psychiatrist's "overpriced" field of action to the "sickest" conditions have resulted in demedicalization of psychiatric services in Canada, shifted to a social service model called mental health services or clinics. Paradoxically it has not been accompanied by a decrease in the use of psychotropic medication which unacceptably, too often reduces the physician's task to the one of writing prescriptions for a large number of patients with whom he (she) has very little direct contact. It puts a particularly heavy burden on the so-called "therapist" who has very little knowledge if any at all of pharmacology, without alleviating the responsability of the psychiatrists who has to decide about the medication.

The team members are most commonly nurses, psychologists, social workers and occupational therapists. Other health workers are also eventually involved like: school teachers, special educators, chaplains,probation officers, recreational therapists etc... Paradoxically, regardless of their basic training and experience, it happens that the members of the team could consider themselves equally competent to assist the patient. In fact, the purport of competence to be involved in various forms of therapy should be based on official professional regulations and recognition as well as on legislation. Many non-medical mental health workers are still far away for that type of accepted standardization.

When decisions to provide access to health care become a political issue, there might be a danger that political solutions take precedence over clinical diagnoses, treatment plans, and processes as well as outcome. The question could then be :access to what?

The quality of training is an essential condition to good quality care but other conditions are no less important for the success of teamwork. The decision to work in a team should be a free choice. The well being of the patient should come first among the objectives once could develop along with a respect for each other's area of competence, and interest for mutual enrichment, a capacity to really share in the decisions,responsibilities, failures and successes. The patient must be informed of the respective responsibilities of each therapist. The optimal functionning of a team implies not only a proper vertical coordination but a horizontal integration of the therapeutic processes in order to avoid, amongst others, duplication, confusion and splitting. Of course, the patient should be made, as much as possible, an active participant in the definition of treatment priorities and in the application of the treatment plan. The assessment of the outcome is often an arduous task mainly with chronic patients but is an important component of the peer review concept. The quality of relationship within the team will quickly

reflect on the quality of the therapy. The patient will promptly pick-up the frustrated therapist unhappy with his (her) task and/ or his (her) peers. It will not take long before the patient tries to split the team work or acts out.

The financial implications of the team concept constitute a very important issue. Considerations should be paid to the amount of time spent discussing about the patient versus the time, devoted to direct patient care. If more time is spent away from the patient than with him(her) one should question his(her) interest in the patient's therapy and the possiblity of counter-transference or a 'giving up' attitude which could also be quickly identified by the patient then feeling abandonned or rejected. There should be some flexibility for informal if not formal opportunity to discuss about the cases in therapy with the team leader as indicated by the development of the therapeutic process and the need for re-adjusting the treatment plan accordingly.

It seems that the team approach is more frequently the reality of the less priviledged groups. The supervision of the work done would differ in quality according to the facilities, their locations and the availability of competent manpower.

The outcome of the team work could only be in many instances what the participants in this process, including the patient, would want it to be. An ongoing attention to the dynamics of the relationship within the group is essential to its good functioming. Problem-solving attitude should start within each one of its members and between the members themselves, in order to spare the patient from becoming the scapegoat or even the victim of such eventual difficulties.

The comments far from being exhaustive, intend to trigger questions among those interested and involved in multidisciplinary approach to patients and so that they may put the question to themselves: Is the team approach for or against the patient ?

"Man is only a reed, the weakest thing in nature : but he is a thinking reed".

Pensées - Pascal

REFERENCES

1. American Psychiatric Association: Guidelines for Psychiatrists in Consultative , Supervisory , or Collaborative Relationship with Non-Medical Therapists. Am.Journ. of Psych. 137, 11, 1489-91, November, 1980.

2. Crawshaw, R.;Key, W.; Psychiatric Teams: A Selective Review of the Literature., Arch. Gen. Psychiatry, 5:105-113, 1961.

3. Heiman, E.M.: The future relationship of psychiatrists with other mental health professionals. Psychiatric Opinion 25-30, October 1978.

4. Langlsey, D.C. Interprofessional Problems in Mental Health., J. Clinical Psychiatry, 41 12, 403-404, December 1980.

5. Mailick, M.D., Ashley,A.A., ; Politics of Interprofessional Collaboration Challenges to Advocacy. Social Case-Work; The Journal of Contemporary Social Work, 131-137, March 1981.

6. Mollica, R.F.: From Asylum to Community: The Threatening Disintegration of Public Psychiatry, New England Journ of Med. 308, 7, 367-373, February 17,1983.

REHABILITATION OF CHRONIC SCHIZOPHRENICS IN A DEVELOPING COUNTRY

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INTRODUCTION

Fountain House, Lahore, has the distinction of being a unique project in the developing countries in the challenging area of the Psychiatric Care and Rehabilitation. The original model of psychiatric services associated with Fountain House model was developed in the 50s and 60s at Fountain House, New York. When Lahore Mental Health Association sought financial and technical assistance from the Department of Health, Education and Social Welfare, Washington, U.S.A. for the establishment of a special Rehabilitation Project for the mentally ill in Lahore, Pakistan, a collaborative link was established with Fountain House, New York.

Rehabilitation Centre in Lahore was started at the end of 1971 as a Half-way House. But very soon as a result of the exchange visits between the Project at Lahore and Fountain House, New York, the Centre at Lahore and its programme was organised on the lines of the model developed at Fountain House, New York. It was, however, found desirable and in fact essential to adopt and modify various components of the programme to suit the special needs of the persons served by Fountain House, Lahore. Over ten years of close collaboration between the two Houses has shown that inspite of diverse cultural settings, the basic ideology can be intimately shared and preserved.

The fundamental ideology of Fountain House model is extremely simple. It believes that most of the suffering of the mentally ill is caused by their isolation from the Society. The image of a mentally ill person usually presented in the medical text books and fiction was that of a person considered unfit for human companionship and, therefore, the Society evolved a procedure of confining them behind high walls and locked doors. The basic need of the mentally ill was acquiring back their right of self respect and personal dignity. All the services associated with the Fountain House model stem from this basic concern.

The following are the important components of the Fountain House model :

CLUB HOUSE FOR MEMBERS

The original Fountain House in New York resulted from concerted efforts in early 1940s by some patients of Rockland State Hospital. Their primary objective was to help each other in getting jobs. They realised that this could only be achieved through propping up each others self confidence. They called themselves "WANA" an Acronym of "We Are Not Alone". Gradually the group grew in strength and was joined by some volunteers. Soon they were able to raise funds to buy a four storey Brownstone on West 47th St., New York which had a small Fountain on its premises. The place was turned into a Club House and was named "Fountain House". The programme for day time activities and an evening recreational programme was developed with the help of dedicated professionals.

Fountain House, Lahore, was initially named "Halfway House" but very soon collaborating links were established with Fountain House, New York which resulted in the identity of views on basic concepts. The label of Halfway House could no longer represent the nature of expanding services. It was, therefore, decided to adopt the name Fountain House in 1973. Since then the collaboration between the two Houses has become a unique experiment in cross-cultural collaboration in the field of psychiatric care and rehabilitation. Membership at Fountain House, New York is open to anyone with a history of psychiatric treatment. At Lahore the members are selected on the basis of a prescribed criteria. One reason for this restriction was the requirement of research. The other more important reason was that being a residential facility, it could not throw its doors wide open. The criteria at present limits membership mainly to Schizophrenics excluding mentally retarded, physically disabled and drug addicts. The membership status is permanent. Access to services is their right as Resident Members. Day Members, Night participants or Casual visitors. Change of status is quite frequent.

PRE-VOCATIONAL DAY PROGRAMME

It has been repeatedly emphasised that psychiatric patients returning to community have to face extreme difficulties in acquiring jobs. This situation is partly a result of unfavourable opinion held by the employers but part of the reason is lack of self-confidence in the psychiatric patients themselves.

It is essential that such persons are provided with an opportunity to test their own ability to handle responsibilities in pleasant and sympathetic environment. The role of the staff in this programme requires an attitude which tends to eliminate distance between the staff and the members. In short the programme is based on members and staff working together towards the goal of purposeful and meaningful living in the community.

The day time activity of the Club House is divided into a number of Units according to the number of jobs which need to be done for the upkeep and running of the Club House. The most important of these Units are Clerical Unit, Kitchen, Snackbar, Washroom, Gardening and Maintenance. The manpower that could not be absorbed in the activities associated with the maintenance of the House are

engaged in other meaningful activities such as Flower Making, Book-binding, Sewing, Handicraft, Plaster of Paris modeling etc.

The main objective of all these activities is to prepare the members for taking up jobs of responsibility outside the House by getting used to working with other people.

TRANSITIONAL EMPLOYMENT PROGRAMME

Even after having gone through the prevocational Day Programme in Fountain House, most of the members are apprehensive about going to work outside the sheltered environment of the House. They fear rejection by employers and unsympathetic behaviour by co-workers. They need further support in handling jobs in the competitive world of business and industry with confidence. The T.E.P. has opened new avenues in this difficult area by enlisting the continued help of employers in Business and Industry in the form of jobs reserved for Fountain House members.

Fountain House, New York has found it possible to make this arrangement with over 150 business firms for the employment of Fountain House members under T.E.P. The impressive result of this experiment have encouraged a number of other rehabilitation centers to adopt T.E.P. programmes in the United States. Fountain House, Lahore, however, has the distinction of being the only rehabilitation centre to adopt this approach outside the United States.

It has taken a good deal of effort and public relationing to convince the business community that the improved mental patients could become useful and productive members of the Society. In the beginning there was a good deal of resistance. The employment situation in Pakistan is very tight and even the able bodied persons with sound mind find it difficult to secure jobs. It was, therefore, advisable to request the employers only for the entry level jobs. The nature of the job is then carefully evaluated by the Social Workers, in some cases by doing the jobs themselves. The working day is then divided into two halfs and each member on T.E.P. is expected to work only for half of the day.

The greatest success in this area was achieved by contacting the Lahore Chamber of Commerce and Industry and through them the interested employers. The notable success in this regard has been the placements with Rustam and Sohrab Bicycle Factory which has provided work for a number of Fountain House members. More recently relationship of this nature has been established with a number of paint shops where the members are used for sorting out various brands and colours. Placement of members in groups has been found to be very satisfactory because of the mutual support by members to each other. Group placement has worked most successfully in nurseries for plants.

In spite of this encouraging break-through in a difficult and challenging area, it has not been found possible to arrange jobs for all the members considered suitable for this programme. A plan was, therefore, worked out for the establishment of business enterprises in the community which would be supervised by the Fountain House members. These enterprises could include snack-bars and grocery

stores. Funds are being provided by the National Institute of Mental Health, U.S.A. for this Project which is expected to be launched during 1983.

The Fountain House programme does not include the training of members in special skills. The experience so far indicates that most of the members come only with academic qualifications but lack useful skills. Typing classes were started as part of the Clerical Unit to help them in finding jobs. The usefulness of this exercise has remained limited because of the high degree of competition of this field. It is now planned to establish a Simulated Workshop either on the premises of the House or as part of a Factory where members will be trained for jobs for which there is a definite market. The Fountain House ideology, however, does not support the concept of sheltered workshops.

FOUNTAIN HOUSE FARM CHUHARKANA

The nature and organisation of Fountain House programme attracts persons with urban background. As over 70 per cent of population of Pakistan resides in rural areas, it is essential that a rehabilitation programme should be developed to suit the needs of persons coming from agricultural background. The Government of the Punjab was approached for the allotment of a piece of agricultural land in the vicinity of Lahore for the establishment of an agricultural farm project. A piece of 25 acres of agricultural land was allotted to Fountain House in 1982 at Chuharkana about 40 kilometer from Lahore. Construction of residential quarters for members was completed in February and the Project was formally inaugurated in March, 1983. The members who live on the Farm are engaged in plantation growing vegetable crops and other farming activities in addition to the maintenance of the place. It is also planned to add a section of cottage Industry to this farm in the near future. Psychiatric consultation and medical services will also be provided for the local population so that the membership from the rural population could be enlarged.

It is envisaged that the simple nature of the agricultural activity will also be helpful as a form of therapy (Agro-therapy) for those members from the urban areas who need to be engaged in healthy outdoor work. This has already been tried on some members and a significant improvement in their physical and mental health was noted.

A research project has been planned to determine the effectiveness of Agro-Therapy in the most challenging domain of Rehabilitation of chronic Schizophrenics. This is going to be a unique experiment in the field of Rehabilitation of mentally ill in a developing country like Pakistan where majority of the population (about 70 per cent) resides in the rural areas.

RELIGIOUS PRACTICES AS PART OF THERAPY

It is being increasingly realized even in the Western Countries that religious values and practices bring tranquality and stability in the lives of the people. Mentally ill are no exception to this rule. The first effort towards the rehabilitation of the mentally ill in the Western Countries were called "moral education". No

modern approach in this area could be called complete and comprehensive without incorporating an element of moral values.

Fountain House, Lahore, has made religious instructions and religious practices an integral part of the daily programme of the House. A mosque has been constructed on the premises which has made it possible for the members to offer the daily prayers together. The mosque is also being used for group activities as such "Milad" and speech contests on religious topics. Occasionally renowned religious leaders are invited to deliver lectures for the enlightenment of members and the staff. Tapes of recitation from Quran by renowned Qaris are also played at times.

The morning programme of the House after breakfast is started by reading of verses from the Holy Quran. Services of Qari have been acquired for this purpose who spends most of his time with the members to motivate them to offer their prayers regularly and lead a clean moral life. It is felt that participation in religious activities has helped not only in strengthening the mental health of members but it has also kept the atmosphere of the House free from moral and sexual deviations usually associated with living in large groups. Another mosque will soon be built on the premises of Agricultural Farm at Chuharkana.

SUMMARY

Fountain House has passed through various developmental stages. It has adopted the ideology of a club-house from Fountain House, New York, alongwith a number of innovative programmes for the rehabilitation of the mentally ill. Through a process of constant experimentation and evaluation, it has evolved a programme and an ideological framework which is in keeping with the religious and cultural requirements of the members served by Fountain House, Lahore.

PRACTICAL SOLUTIONS FOR PROBLEMS IN PSYCHOSOCIAL REHABILITATION IN DEVELOPING COUNTRIES

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INTRODUCTION

In the developing countries of the world, the level of psychiatric care varies widely. In some countries, there are rudimentary services such as a mental hospital with a few psychiatrists. Others have more elaborate networks of clinics with several hospitals and dozens of psychiatrists. Yet others are at the other end of the scale, often with one or two psychiatrists caring for all the mentally ill in the country. How the latter can cope is often beyond the imagination of most psychiatrists in the developed world. Unfortunately, this state of affairs continues even in this day and age. What are the reasons for this and other ills that psychiatry faces in developing countries and is there anything that can be done?

Unfortunately, the answers are not simple or quick in coming. For one, many of the handicaps faced by psychiatry are problems tied in closely with attitudes to mental illness the world over. For another, they are not limited to psychiatry Priorities in developing countries often are such that psychiatry takes a back-seat - having less by way of budgets, resources and manpower than other projects, be they defence, roads or ports. Some answers also lie in the fact that health services of pre-independent times seldom emphasised psychiatric services and so the old, dilapidated and often neglected mental hospitals continue with little change and often some deterioration. In short, the lot of the mentally ill is indeed not very bright.

Obviously, with this background, it is not difficult to understand that development of sub-specialities in psychiatry tends to be slow if at all in developing countries. Child psychiatry for example is still rudimentary in the Asean countries with less than two dozen child psychiatrists for over 250 million people. Psychiatric rehabilitation in developing countries is another speciality that has few proponents. Rehabilitation as a science is not clearly understood and its principles seldom practiced to their fullest extent where they are of greater value. This is of course also compounded by shortage of numbers of occupational therapists, rehabilitation centres and sheltered workshops; such innovations as industrial rehabilitation units for psychiatric patients are seldom, if ever, seen in developing countries.

Even in this rather depressing situation however, several points can be made for improvement if only the problem is recognised. Psychosocial rehabilitation of the mentally ill must be accepted not as a luxury but a necessity. It is a necessity not only because it can help prevent deterioration in vulnerable individuals but because it is an integral part of psychiatric care. No longer can psychiatric care be limited to management of acutely ill patients who are then kept out of sight in high-walled institutions. Once this principle has been accepted at the highest level, the practical part of the solutions to the problems in psychosocial rehabilitation can be put into practice.

PRACTICAL SOLUTIONS

(a) Manpower

Central to any discussion of development of psychiatric services in the developing world is the problem of manpower. Despite the many steps taken to train professional and paraprofessional manpower in psychiatry in the past two decades, the effective output of such manpower in developing countries has been disappointing. The ratio of psychiatrists to population in most developing countries is nowhere near the 1 : 100,000 which has been pointed out by RMPA(1). It is true that many trainees were sent for training especially in the developing countries - but failed to return on qualifying. Yet others returned to their countries of origin according to Carstairs (2) only to be

disappointed by the conditions there and emigrated to their trainer-countries or elsewhere.

If psychosocial rehabilitation is to be a living reality within psychiatric care, the need is for psychiatrists, psychiatric social workers, psychologists and occupational therapists to be trained in their own countries. If that is uneconomical, they should be trained in a regional centre set up for a group of developing countries. This aspect of training can only be ignored if the brain-drain that has gone on for the past two decades is to continue. Primary training of rehabilitation workers in their national or regional centres may be supplemented by advanced training in centres in the developed countries after several years of practice and service.

(b) Integration of Psychosocial Rehabilitation

If psychosocial rehabilitation is to be a practical reality in the developing countries, it must begin to be a useful and practical science. What goes under the name of rehabilitation in many institutions is the repetitive and questionable recovery of wool from old army stockings done in dead silence. Psychosocial rehabilitation must become in its own right a rehabilitative science equal to rehabilitation of the blind, the physically handicapped or the mentally retarded. It must develop its own principles and guidelines and objectives.

(c) Conceptual Framework

To be able to function as a speciality, the developing countries must adopt a conceptual framework for psychosocial rehabilitation. The aims and objects of effective psychiatric rehabilitation must be within the capacity of developing countries to achieve and in consonant with their cultural values. Many rehabilitative efforts fail because of lack of realisation that rehabilitative efforts are not entirely geared to the local needs.

As an example, recent studies show that patients with schizophrenia benefit by family support systems in the developing countries rather than the hostel-like atmosphere of a half-way house. Can rehabilitation of the mentally ill be geared to strengthening and reinforcing family care for their mentally ill? If so, can the rehabilitation specialist do this within the cultural and social context in a developing country?

(d) Expert Help from the Developed World

In most developing countries, the help by foreign experts has been a living reality. There is little doubt that transfer of technology is a desirable goal for most specialities. The question is how and by whom? While accepting that training of the psychosocial rehabilitation professional is best done at home or regionally, the help given by an overseas specialist can help the locally-based programme in many ways. It can also help the expert from overseas understand some of the complex organisational and practical problems confronting his student in the developing country. Many problems can be solved by transfer of technology but many others reject transplant of technology. What may be useful is for the expert from the developed world to work together with his colleagues on the spot to innovate new techniques and solutions.

It would be useful here to emphasize that selection of rehabilitation experts to help programmes in developing countries should be done by both countries to prevent problems that arise from different expectations.

(e) Model Programmes in Psychosocial Rehabilitation

While it may be said that models only remain as models, it is also true that without models, change occurs if at all haphazardly or by fits and starts. A small but functional psychosocial rehabilitation programme that is practicable within the resources and environment of a developing country can play an important role in stimulating the growth of psychosocial rehabilitation programmes. Even this model may have to be modified to suit individual countries' needs, going to show the complex nature of spreading knowledge worldwide.

THE UNIVERSITY HOSPITAL PSYCHOSOCIAL REHABILITATION PROGRAMME IN MALAYSIA

This programme was started in 1971 at the University Hospital in Kuala Lumpur. With the aim of not only rehabilitating the psychosocially disabled but also as a concurrent day treatment facility for patients with psychiatric illnesses. Its objectives are to treat and rehabilitate psychiatric patients on an outpatient basis by use of group techniques in a therapeutic community setting.

It consists of:
(a) A Day Centre programme
(b) Series of weekly group psychotherapies
(c) A Sheltered Workshop
(d) Weekly group therapy sessions for physically handicapped patients
(e) Home industry
(f) Ex-members' Club held monthly.

The centre is located in one large room of the 850-bedded University Hospital's multidiscipline rehabilitation unit. The activities take place in that room and other rooms and facilities shared with other units.

DAY CENTRE PROGRAMME

This programme admits patients above fifteen years of age of most diagnoses except addictions and serious personality disorders from the 56-bedded inpatient psychiatric facility or the polyclinics or other wards of the hospital. The average length of stay is three months for a maximum of fifteen (15) patients at any one time. The centre's programme revolves around the daily one and a half hour ($1\frac{1}{2}$ hr.) group therapy session and group activities. There are occupational therapy, psychodrama, cooking, swimming, relaxation and assertive therapy sessions spread throughout the five-day week. Medication is given to those who require them. The centre's staff consist of:

Part-time - 1 psychiatrist
1 medical officer (trainee psychiatrist)
1 social worker
1 occupational therapist

Full-time - 1 staff nurse
1 assistant nurse
1 attendant

Medical students and student nurses at the University Hospital also spend a week observing the activities at the centre.

SHELTERED WORKSHOP

The Sheltered Workshop is run by a psychiatrist and an occupational therapist, both working part-time and an attendant who works full-time. Referrals are from the Inpatient Unit, the Day Centre or the Polyclinics. Patients at this centre work to an industrial type work schedule with incentives and bonuses for good workers, schedules, punctuality and delivery times are strictly adhered to. Payment is on a piece basis. Industrial sub-contracts

include assembly, light plastics and servicing work. The average length of stay is six to nine months and about one-fourth to one-third are successful in getting open employment while about another third are on permanent sheltered employment.

This workshop has both physically as well as psychiatrically handicapped patients as this is found to be useful for all categories of rehabilitees.

THE OUTPATIENT THERAPIES AND GROUP THERAPIES

The outpatient therapies, group therapies, Ex-members' Club and home industry projects are usually reserved for patients who are relatively well but require periodic help. The outpatient group therapy is a time-limited (5 months) group of not more than eight (8) patients and is run by one psychiatrist, one nurse and one trainee psychiatrist. It admits both recovering psychotic and neurotic patients as well as new patients who can function in a group. The home industry project is supervised by one occupational therapist and one attendant.

CONCLUSION

The programme at the University Hospital utilises part-time staff for the most part and is cost-effective compared to a twenty-four (24 hr.) inpatient psychiatric facility. It also is the main rehabilitation facility for psychiatric patients in the hospital and the community. Through trainee doctors and nurses attached to the programme at various times, similar programmes have been started in other psychiatric units in urban areas of Malaysia. It appears to be an effective model for use by urban psychiatric units in the country.

REFERENCES

1. Royal Medico-Psychological Association, The Demand for Psychiatrists in the Training of Psychiatrists, Edited by G.F.M. Russel & H.J. Walton, Headly Brothers Ltd., Kent, U.K., pg. 11 (1969).

2. Carstairs, Psychiatric Training for Foreign Medical Graduates in Comparison to Psychiatric Studies, (Ed. A. Forrest) Churchill and Livingstone Press, Edinburgh (1973).

SOCIAL AND ECONOMIC DETERMINANTS OF REHABILITATION STRATEGIES

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The term rehabilitation presumes the loss of skill and efficiency. This may be due to "disuse atrophy" phenomenon occasioned by the lack of use of skill as a result of long illness with or without hospitalization. It may also be due to the nature of the illness. There is some evidence that patients who have been hospitalized for a long time require more time for rehabilitation than those who have been ill for an equal length of time but not hospitalized for as long - or not hospitalized at all.

Whether the loss of skill is due to long periods of illness or nature of illness, it is necessary to be aware of the residual scar left behind before setting a goal for rehabilitation. It will be too optimistic and unrealistic to expect in all cases a return to status quo ante through rehabilitation.

The need for rehabilitation varies roughly proportionately to the length of illness, and to the severity of illness in terms of the disintegration of the personality. The earlier the therapeutic intervention in the course of the illness, the less the need for rehabilitation, especially in these days of potent and often effective treatment armamentaria. In addition to the availability of the improved treatment, there has also been a change in the general management of psychiatric patients - initiating treatment where possible in the community on ambulatory basis, keeping hospitalized patients usefully and constructively employed in the area of their competence, where possible, hospitalizing patients

for the shortest possible period. These progressive changes have helped to reduce the level of loss of skill in mentally ill patients.

The strategy for rehabilitation depends on the socio-economic factors within a given society. In a society which is fragmented and isolating, a society where emphasis is strong on individualism, and where it is believed that independence through work is the ideal, gainful work is the focus of the strategy. This is not to suggest that social rehabilitation is neglected. Rather the emphasis is on occupation.

In such a society most people are wage earners. There are employment agencies which help to place unemployed people in appropriate work situations. The labour laws in some of these societies enjoin employers of labour over and above a given number to reserve a percentage of their labour force for the disabled, especially the physically disabled. On the other hand there are unemployment benefits enjoyed by those who are not working. Usually a person earns more if he is at work, so there is theoretically the incentive to work if one wants to earn more than the unemployment benefit. Of course there is the unusual and obviously unintended situation where it pays more not to work than to work. There is also the sickness benefit factor which unfortunately can perpetuate the state of illness.

In such a society, it is understandable that the emphasis on rehabilitation is work. It has to be noted that not all societies in the world enjoy the facilities mentioned above. On the other hand some of them have other social factors on which their strategy for rehabilitation can be based.

To start with, a sick patient, whether physically or mentally sick, is not treated in isolation from his relatives. If he has to stay with the traditional healer to facilitate treatment, it is his relatives who cater for his animal needs. If he is hospitalized in a modern setting, the relatives, especially the traditional ones expect to perform the same role. Unfortunately this role is not usually allowed to be performed in the modern hospital, and those less traditional relatives, especially the urbanized ones, are unable to perform this role because they are in wage earning employment.

While the patient is with the traditional healer, and his mental state permits, he is expected to participate in some chores, not only

in the service of his family, but also in the service of the traditional healer. To this extent he is made to be active. He is not exposed to the same degree of ennui or boredom characteristic of some long stay psychiatric hospitals. If there are opportunities for him to practice his occupational skills, as there are often for farming, he is encouraged to engage in this.

It has to be admitted that in some cases, as a result of the physical restraint employed, and some form of physical treatment, there may be added physical disability inflicted on patients by traditional healers. This paper is however only focussing attention on practices which reduce the need for a rehabilitation programme.

In some modern psychiatric hospitals in developing countries, the traditional practice of involving relatives in the treatment programme is maintained and also the practice of patients participating in ward chores and relevant occupational therapy - to maintain the skill of patients where possible.

As most patients in developing countries are not wage earners, but are engaged in traditional occupations either in the family or on individual basis, the strategy of rehabilitation has to take this into account. In fact the strategy is often directed towards social rather than occupational rehabilitation. By social rehabilitation we mean the recovery of social skills that may have been impaired through illness, and participation in social activities. This participation implies the acceptance of the sick person as a functioning individual and not as an outcast. It has been observed that social rehabilitation.later leads to occupational rehabilitation whereas occupational rehabilitation does not necessarily lead to social rehabilitation.

The following two contrasting cases illustrate the point. Mr. A.A. was a highly educated person on the verge of obtaining his Ph.D. when it became evident that he was psychotic. He was abroad in Europe. He returned home and was able to secure a job until his condition deteriorated. He lost the job and over the years he became virtually a vagrant psychotic. Old friends and a particular secondary school teacher of his managed to get him into a psychiatric hospital for treatment. He responded fairly well to treatment. A modest job, well below his academic qualifications, was found for him to start, and he was going from the hospital to work. After a while it was thought that he should be discharged and settled in

the community so that he could continue his job, and at the same time remain under psychiatric surveillance.

He had no close relatives alive, but he succeeded in producing two young boys who were going to look after him, do his laundry, prepare his food and clean his rooms. The psychiatrist had a talk with these two boys about their role and requested them to report to him if they noticed any negative change in the patient's behaviour. The patient was duly discharged and he held the job for a while. After a few months his behaviour at work deteriorated and he refused to come to keep his appointment in the hospital. The two boys never reported to the psychiatrist. The patient lost his job and was back on the street. The outcome might have been different if a social worker was available in the hospital, but there was none.

The other patient, Mr. S.J. was a university graduate and he had a good administrative job. He also had a psychotic illness and he lost his job as a result. He also became a vagrant sleeping rough under the eaves of large buildings. His old friends and schoolmates succeeded in getting him into a local psychiatric hospital. He responded fairly well to treatment. His old school-days girl-friend who was married and divorced took him in when he was discharged as he had no close relative except a younger sister who was ineffective. He settled down in this environment and was re-socialized. He married the girl-friend and they had one or two children.

The two cases were similar in most aspects. Both were highly educated, both had practically no relatives, both had psychotic illnesses, both became vagrants, both were eventually hospitalized, and both responded fairly well to treatment. The major difference was that Mr. A.A.'s rehabilitation was focussed on a job, while Mr.S.J. was taken in by a girl-friend and later got a job. The outcome was that Mr. A.A. relapsed and was back on the street, while Mr. S.J. continued to do well.

Another case was that of a young woman who had killed her two young children and failed to consummate her suicide. She had been going through a stressful marital situation which had culminated in this event. She was sent to a psychiatric hospital for observation and treatment. In view of the cultural significance of a mother killing her own children, it was thought that she would be rejected by the society, and this might lead her to consummate her suicide. It was one of the rare cases the psychiatrists

considered to be of "inevitable suicide". This possibility was discussed with the patient who said she would relocate to another town where the stigma of killing her children would not be known and she would start life afresh.

She had some secretarial training and had been working as a sort of secretary. She tried to keep her skill while in hospital in the Occupational Therapy Department, and in the Administration of the hospital.

She was the only child of her mother who had been cohabiting with a highly placed civil servant many years. This man took ill and died while this young woman was in the hospital. Even though her relationship with her mother was not the best, she pleaded to be discharged to be with her mother who could well do with her comforting company at that critical point in her life. She was discharged. She went and stayed with her through the funeral ceremony and longer than the traditional period of mourning which is forty days during which she was obliged to remain indoors. It would appear that this period helped to temper the stigma attached to the patient's psychotic behaviour and gave her the unique opportunity of re-entering society again. She never returned to the hospital. She eventually remarried and had other children.

In this case the social obligation which she had to meet provided the key for her rehabilitation.

There are several other examples of where the need to meet a social obligation has led ex-patients to work to earn money. One notable case is that of a young man who after discharge from hospital for a psychotic illness did not work until his younger sister was going to get married. In order to earn some money to meet his obligation regarding his sister's marriage, he went to work.

One can also mention the observation of students who have repatriated to their country (Nigeria) from abroad because of psychotic illness. Some of the students appear to have spontaneous remission on returning to their own environment; others responded to modern treatment rapidly and they were able to take their place in society socially and occupationally. One notable example was a woman who had been in a psychiatric hospital in England for about 6 years before she was repatriated. She was hospitalized back home (Nigeria) for less than 6 months when she recovered and returned to the teaching profession in which she was engaged before she went abroad.

The point of this observation is that rehabilitation can be expedited by the return to a familiar social environment. That tends to support the idea of social rehabilitation as being of primary importance in total rehabilitation.

It is much easier to rehabilitate those patients from traditional backgrounds and traditional occupations which are usually family centered. These occupations do not usually require the stress and strain of promptitude, and a lot of connected chores can be carried out at the individual's own pace. Furthermore, in the tropics people live more outside than inside houses, and they are exposed to contact with other people. The tendency to solitary and isolated existence is considerably reduced. This situation helps the resocialization and rehabilitation of patients.

It was noted in a study of vagrant psychotics in Nigeria that in spite of the fact that some of them had been psychotic for many years, they did not suffer the same degree of personality disintegration as much as those who had been hospitalized for an equally long time. This will suggest that the opportunity to interact freely with other people helps to preserve their personality from total disintegration. This applies only to schizophrenics who were observed to loiter in localities where there was movement of a large number of people like market places, lorry stations and commercial areas. Depressive patients on the other hand were found at the periphery of the town where there were few people.

The point of this observation is that a long period of hospitalization does things to schizophrenic patients which make rehabilitation more difficult, especially in hospitals where they are kept indoors most of the time because of the weather.

While it is necessary to be flexible about the goal of rehabilitation, one should not set too high a goal, failure to attain which may be frustrating to the patient and the staff. On the other hand efforts can be made to improve the quality of life of the patient in any way possible. An effort in this direction was made in my former hospital, where we had patients of different levels of modernization.

The Occupational Therapy Department prepared kitchens at different levels of modernization. Female patients who attended the Department were introduced to the level with which they were familiar. After spending some time at this level of cooking, they

could move to the next higher level which would not be too expensive for them to provide at home. It might be just simple arrangement. For instance, instead of having their grinding stone on the ground, at one level, it was raised up an a solid support of wood at the next level. This not only made the chore of grinding more comfortable, it also made the process more hygienic. This same was done with cooking by raising the stove to a high comfortable level instead of being on the ground.

It was reckoned that this would improve their kitchens when they returned home and consequently improve their quality of life. Unfortunately, an evaluation of this exercise was not carried out to find out what impact it really made. Whether it made an impact or not, their cooking skill was maintained while they were hospitalized.

It was always felt that period of hospitalization could be utilized not only for the treatment and rehabilitation of the mentally ill, but also for introducing to the life of the patients a new dimension in terms of creative activities which could enrich and improve their quality of life. To this end vegetable and ornamental gardening around the ward was proposed. Earlier on in the history of the hospital, it was possible to give the patients some incentive in the form of contraband goods seized by the Customs and donated to the hospital. This donation stopped and it had not been possible to find any substitute for incentive.

The approach to rehabilitation strategies should take into account a number of factors, some of the more important of which have been briefly discussed.

OBSTACLES TO EFFECTIVE AFTERCARE

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SUMMARY

De-institutionalization of chronic patients was introduced over two decades ago with much enthusiasm. The author points out the reasons for the less than optimal results and reviews the pitfalls in the much needed research set-ups. Recommendations are made for a more focused, flexible and implementable approach in aftercare facilities.

BACKGROUND

In the past two decades the post-hospitalization follow-up of psychiatric patients has been radically affected by the concept of community care. In many countries, following an acute episode, patients have an alternative to long term stay in a mental hospital. The latter has suffered from a tarnished image at the same time. Following the introduction of major tranquilizers in the early fifties, a number of pioneering studies have documented the deleterious effects of long term hospitalization (1,2,3). The term "institutionalism" was coined then with a clearly pejorative meaning (4). The insights and extrapollations from these observations together with major advances in psycho-pharmacology gave a major impetus to the reorganization of mental health systems. The expectations were that the combination of psychoactive drugs and psycho-social management will eliminate the need for long term hospitalization and would eradicate chronic mental illness itself. It was assumed that mental hospitals were a-priori unsuitable for chronic care and that only extra-mural treatment could be effective and humane at once. Furthermore, it was postulated that the

population at large will embrace this new philosophy and support it financially and in deeds.

PITFALLS IN COMMUNITY CARE

However these hypotheses resembled more wishful thinking than reality. Little research or long term planning preceded the rapid transfer of patients from the mental hospitals to non-institutional quarters. The "communities" were ill prepared - both in terms of alternate services and attitudes - for the massive influx of chronic patients. As Panzetta pointed out, the whole notion of the "community" being a tightly knit, caring, independant group of people with common values has been a fallacy. Our real communities are much more fragmented, with people's relationships being formed along rules, guidelines and regulations (5). Hume offered a more realistic definition by stating that our communities are a network of systems where the intergovernmental, interagency, interprofessional, interpersonal and administrative/consumer relationships are viewed as essential to the initiation, development and effective utilization of all available resources for remedial and rehabilitative measures in the field of mental health (6).

At first, sheer enthusiasm and the huge financial resources allocated to such programs, primarily in the United States have created an illusion of success. The population of the mental hospitals declined dramatically between 1955-1975 (7). At the same time the average length of stay in institutions has also decreased significantly (8). Furthermore this phenomenon was accompanied by a several-fold increase in the number of readmissions (9) creating an optic illusion dubbed "the revolving door" policy. Through medication and rudimentary other services a portion of the discharged patients was being kept outside the hospitals, while another group of patients - probably more disturbed or more active and/or demanding - has taken up an inordinate percentage of readmissions.

The patients released into the community did not fare as well as the early proponents of de-institutionalization assumed. The literature of the past decade holds many critical reviews on the condition of these patients (10,11). The dilapidated rooming homes of the downtown cores of large cities have replaced the asylums. There, most patients watch television or do nothing, are often poorly feed and live in unhygienic conditions. They maintain loose, irregular contacts with social services and many never frequent medical facilities for follow-up. Chronic patients are often ridiculed and abused by residents of the area, are at the mercy of their landlords and without skills to mobilize support or advocacy. In a study titled "The New Asylums" Lamb (12) points out that 90% of the residents of such houses have never tried nor succeeded to live alone, were unable to cope with regular social and vocational demands, could not withstand life's pressures and exhibited a marked poverty of interpersonal relationships. Besides, these very seriously impaired patients are often looked after in community

clinics by an increasingly less competent group of mental health professionals (13). To aggravate the situation, considerable gaps have been observed between identified needs for a given patient population and referrals made to existing community programs (14). Last but not least, there is a strong indication that when aftercare planning is not carefully coordinated between the hospital and community agency, less than 20% of the discharged patients are likely to end up in the available neighbourhood set-ups (15).

STATE OF RESEARCH

The lack of proper conceptualization and relevant research in early stages of community program developments resulted in considerable disillusionment and backlash. When cuts in services are unavoidable, due to limited resources, then priorities need to be set instead of aiming at comprehensive but unimplementable projects.

Research over the past five years indicates how complex the planning and evaluation of community care designs has become. We have learned the importance of identifing separately the various factors affecting outcome. In addition, we know now that the target population for each service or therapeutic intervention needs to be specifically recognized because the "grapeshot" approach has been ineffectual and wasteful.

The main problem areas identified in current research set-ups are: a) Potentially biased allocation of patients, b) Inadequate information on concommitant drug therapy, c) Lack of agreement on clear diagnostic criteria, d) Studies are usually done on small selected group of patients under experimental conditions - unlike the reality of thousands of chronic patients, e) Newer, optimal care providing in-patient programs were seldom used as controls - revealing a partiality toward the community experiment (16).

Test and Stein pointed out that some of the beneficial results seen in experimental studies could be related to the amount of interest and support expressed to the patients involved (17).

Future research evaluating community support systems will have to set the following criteria for relevance and effectiveness: a) Is the patient now functioning better in terms of his social adaptation, psychiatric status and vocational performance than he would be without the programs? b) Is the patient satisfied with his treatment? c) Assess the stress experienced by the family of the chronic patient, d) How stable has been the treating staff? -knowing that program effectiveness hinges on continuity of care, e) Studies on community acceptance to determine if improved community support systems can reduce resistance to psychiatric patients, f) Whether programs offered to different target populations act in a

complimentary or mutually adverse fashion? (18).

RECOMMENDATIONS

Better designed studies are only one component in the planning of more successful aftercare programs. A number of conceptual and practical changes emanating from already available experience could be implemented in the foreseeable time. There is an urgent need to get away from polarized "either-or" models whether they apply to matters of philosophy, management or scope. We have to think in more flexible, practical terms, integrating the true need of the patient with the socio political and fiscal realities. Planning and execution should be considered at a gradual pace and to be of manageable proportions, for clearly defined patient populations. Gone are the days when grandiose, comprehensive projects for a whole gamut of the mentally ill would be conceived and carried out with little pretesting on a smaller scale.

The point is not to prove that community care works in theory and in a few controlled experiemental studies. It is the large number of unselected groups of psychiatric patients, who do not get the attention of the researchers and who do not receive a de facto alternative to an enlightened, contemporary in-patient stay who are to be considered. We have to do away with the misleading extrapollation of a few, often slanted or inadequately designed studies to whole patient populations, living in and attended to in a very different environment from the one in which the formal investigation took place.

Community care should not be considered anymore the only aftercare alternative for <u>all</u> psychiatric patients. There is evidence indicating that indiscriminate de-institutionalization carried out on a large scale has been harmful to many chronic patients (16,19). The latter should not be discharged from an institution if no specific psycho social, residential vocational and recreational facilities have been secured for them outside the hospital. Discharge planning has to become an early collaborative task, not a last minute haphazard scramble. It has to involve community based professionals if the patient is to be maintained and not just "parachuted" there. Furthermore the coordination of a continuous follow-up - preferably with one identified person in charge - has to be assured to avoid preventable readmissions. Effective access to information regarding the availability of community resources needs to be guaranteed through a central data collecting and preferably standard setting and enforcing agency (20, 24).

We need to differentiate between various categories of the mentally ill in need of follow-up. Chronic patients, usually

schizophrenics, with several long-term admissions and a history of unemployment often do not survive in the community and will need repeated readmissions (21). Patients who have had one or two hospitalizations, held jobs in the past and have some social supports available to them are most likely to get helped in a community setting. Among the latter group we will have to find out more clearly which type of patient benefits most from what type of service and facility offered. For the chronic schizophrenic who might have never had a hold in the community, a stay in a resonable up-to-date, patient-friendly ward milieu could be the optimal environment. However, even patients with several admissions should be asked as to their preferences. Family members, if available and involved, need to be consulted as well.

An indiscriminate condemnation of psychiatric hospitals was common until recently. However accumulated evidence indicates that for many chronic patients the predictability, consistency, the order and availability of comprehensive medical, dental, social and rehabilitative services have represented a major asset. Such patients find a safe shelter in the hospital and their admission offers relief to the community and family. A most recent report by the Group For The Advancement In Psychiatry (GAP) succintly stated that "realistically it does not seem possible that all the functions of a long term public hospital can be replaced by any combination of even adequately financed community services" (22).

Field studies clearly show this need for inpatient beds for chronic patients (23,24) and a concommitant demand for community based housing, vocational and recreational facilities for a less impaired patient population (25).

As fiscal resources are limited, each community or level of government has to set their priorities in terms of which patient population can they support most. Some hard choices are likely to be made because many programs are competing for the same financial resources. It seems to this author, that chronic schizophrencis, for example, are likely to benefit as much or more from the modernizing and better staffing of mental hospitals as from expensive but inadequate or underutilized community based services. Rather than trying to provide little to all patients in community facilities it would deem more appropriate to channel our efforts towards projects which are likely to be considerable more effective in the light of recent experience. Such an approach would lessen ineffective fiscal fragmentation and is likely to make evaluation of variants effecting outcome easier.

The quality of community housing would be improved if boarding home operators were offered appropriate training programs (26) along with monetary incentives. For community based programs to be

actually utilized they have to be within reach of the patient's residence or he has to be provided with means of adequate transporation.

In addition, it is difficult to maintain a satisfactory self image and find opportunities to interact with others in the absence of a job. The ego- organizing effect of work has been recognized long ago and thus sheltered workshops need to be available as a first step to some - as an acceptable alternative to others - to a meaningful employment.

Last but not least, aside from educating the public at large for an increased understanding of the mentally ill, special efforts have to be directed to the neighbourhoods where boarding - and halfway houses are situated. This is likely to increase the residents' tolerance to the ex-patients among them.

We have to accept that no single measure offers a panacea for effective aftercare. However, if we are ready to contemplate practical, scaled down, specific courses of action for distinct target populations then we have enough acculumated knowledge to implement them in the very near future.

REFERENCES

1. Bettelheim, B., Sylvester, E.: A therapeutic milieu. Am. J. Orthopsychiatry 18: 191-206, 1948.
2. Goffman, E.: Asylums, Doubleday, New York. 1961.
3. Stanton, A.H., Schwartz, M.S.: The mental hospital. Basic Books, New York, 1954.
4. Wing, J.K.: Institutionalism in mental hospitals. J. Soc. Clin. Psychol. 1: 38-51, 1962.
5. Panzetta, A.F.: The concept of community: the short circuit of the mental health movement. Arch. Gen. Psychiatry 25: 291-297, 1971.
6. Hume, P.B.: Principles of community mental health practice. In: American Handbook of Psychiatry, Vol. 2, ed. Caplan, G., Basic Books, New York, 1975.
7. Bassuk, E.L., Gerson, S.: De-institutionalization and mental health services, Scientific American 238:2, 46-53, 1978.
8. Smith, W.G., Krzyzanowki, M., Heinemann, R.: Impact of community mental health programs on hospitalization for mental illness. Illinois Med. J. 153:5, 359-363, 1978.
9. Fisher, L., Freeman, S.J.J.: Community Resources Consultants: an experimental approach to aftercare. Canada's Mental Health 24:1, 33-36, 1976.
10. Bachrach, L.L.: A note on some recent studies of released mental hospital patients in the community. Am. J. Psychiatry 133:1, 73-75, 1976.

11. Lamb, H.R., Boerzel, V.: Discharged mental patients - are they really in the community? Arc. Gen. Psychiatry 24: 29-34, 1971
12. Lamb, H.R.: The new asylums in the community. Arch. Gen. Psychiatry 36: 129-134, 1979.
13. Psychiatric News: pp. 16-17, September 4, 1981.
14. Community Resources Consultants and Social Community Psychiatry Section, Clarke Institute of Psychiatry, Toronto. Psychiatric Aftercare in Metropolitan Toronto, Adult Community Mental Health Programs Branch, Ontario Ministry of Health, April 1981.
15. Globe and Mail, Toronto, March 13, 1981.
16. Braun, P., Kochansky, G., et al: Overview: deinstitutionalization of psychiatric patients, a critical review of outcome studies. Amer. J. Psychiatry 138:6, 737-749, 1981.
17. Test, M.A., Stein, L.I.: Alternatives to mental hospital treatment. Arch. Gen. Psychiatry 37: 409-412, 1980.
18. Schulberg, H.C., Bromet, E.: Strategies for evaluating the outcome of community services for the chronically mentally ill. Amer. J. Psychiatry 138:7, 930-935, 1981.
19. Salvendy, J.T.: De-institutionalization of the mentally ill: expectations, reality and future outlook. In: Out-patient psychiatry: progress, treatment, prevention. Eds. Kogan,R ., Salvendy, J.T., University of Alabama Press, University, Alabama, 1984 (in press).
20. Salvendy, J.T.: A practical approach to tertiary prevention. Israel Ann. Psychiatry 13:4, 364-371, 1975.
21. Braff, Y., Lefkowitz, M.M.: Community mental health treatment: what works for whom? Psychiatric Quarterly 51:2, 119-134, 1979.
22. Psychiatric News, pp. 26-27, January 7, 1983.
23. Fowler, G.: A needs-assessment method for planning alternatives to hospitalization. Hosp. Comm. Psychiatry 31:1, 41-45, 1980.
24. Gruenberg, E.M., Archer, J.: Abandonment of responsibility for the seriously mentally ill. Millbank Memorial Fund Quarterly 57:4, 485-506, 1979.
25. Solomon, E.G., Baird, R., Everstine, L., Escobar, A.J.: Assessing the community care of chronic psychotic patients. Hosp. Comm. Psychiatry, 31:2, 113-116, 1980.
26. Marshall, J.: Madness- an indictment of the mental health care system in Ontario. Ontario Public Service Employees Union, p. 150, 1982.

A NATIONAL SURVEY OF NEW LONG STAY PSYCHIATRIC INPATIENTS

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A generation of psychiatric patients has now been exposed to the concept of community care, a central idea of which is that long-term inpatient care is to be avoided wherever possible. This has led to a considerable reduction in the number of non-geriatric long-stay beds. However, much psychiatric illness runs a chronic course and inevitably some patients still need to be in hospital for lengthy periods of time. These are the 'new long stay'.

In recent years there has been no comprehensive survey of the new long-stay; the last major review was in 1972/3 when Mann and Cree examined patients in 15 hospitals selected randomly in England and Wales (Mann and Cree, 1976).

We have carried out a survey for several reasons. Firstly, it will help determine the number of such patients and thus identify their bed needs. Secondly, it will determine their rehabilitation prospects. Thirdly, a comparison between different hospitals might identify different practices in the care and management of such patients - with lessons to be learned by everyone.

We wish to report some of the main findings of the survey; a fuller description is given elsewhere (McCreadie et al, 1983).

METHOD

A letter was sent to every psychiatric hospital in Scotland outlining the project and inviting its participation. Fourteen psychiatric hospitals responded and a further two psychiatric units in general hospitals which shared a catchment area with two of the psychiatric hospitals replied saying they had no new chronic in-patients.

The 14 hospitals are spread throughout Scotland, covering most regions. The catchment population served is 2.86 million, 56 per cent of the Scottish population. This indicates the survey is likely to be representative of the findings in Scotland as a whole: there was a wide range of hospitals serving urban, rural and mixed catchment areas.

Each hospital identified on 1 March 1983 all new chronics within that hospital. A new chronic was defined as a patient aged 18-64 years who on the census date had been in hospital more than one but less than six years. The following demographic, hospital and clinical information was recorded: patient's sex, age and marital status, date of admission, length of illness (estimated from date of first psychiatric admission) and number of previous admissions; type of ward; parole and legal status; occupational activity within and outside the hospital; mobility; principal diagnosis (that is, the illness primarily responsible for the patient's continued stay in hospital). Also, the consultant responsible for each patient, in discussion with other members of the team, assessed his rehabilitation status through the use of the Morningside Rehabilitation Status Scale (MRSS) (Affleck and McGuire, 1983); he also indicated where the patient would be best accommodated and the activity in which he could best be employed on the assumption that all necessary facilities could be made immediately available in the hospital's catchment area.

RESULTS

The census identified 571 new chronics, which, with a catchment population of 2.86 million, indicates a bed occupancy of 20 per 100,000 of the general population. However, the range among hospitals was great, 12-29 beds per 100,000 (see below). The number of patients whose current admission was the first to psychiatric care was 166, a bed occupancy of 5.8 per 100,000.

Demographic Results

The majority of patients were male (60 per cent) and single (50 per cent) and almost half (43 per cent) were over 55 years of age. First admissions were significantly older and less often single.

Hospital Data

Twice as many patients had been in hospital one to two years as compared with five to six years. This attrition rate was almost entirely due to a fall in the numbers of readmissions. A third of patients had been ill longer than 10 years, a figure rising to 47 per cent among readmissions.

The majority (71 per cent) were in open wards but only a small number (17 per cent) in areas designated as rehabilitation wards. Fifty-six per cent of all patients, but significantly fewer first admissions, had full parole. Eighty-two per cent were informal patients.

Thirty-five per cent, but significantly more among the first admissions (45 per cent), did not take part in activities within the hospital. Approximately equal numbers attended industrial or occupational therapy.

Clinical Results

Schizophrenia was the most common diagnosis (44 per cent) with organic brain disease accounting for a further 30 per cent. However, only 24 per cent of first admissions had schizophrenia, and 53 per cent organic brain disease. These figures are significantly different from, and virtually the reverse of, those for readmissions (52 per cent and 21 per cent respectively). There were also significantly more manic-depressives among readmissions.

Accommodation and Occupation Needs

In the opinion of the consultant and other members of the team responsible for the patient 38 per cent of patients would not need to be in hospital if other accommodation were available. One-fifth could be accommodated in a staffed hostel. However, 72 per cent of first admissions were appropriately placed in hospital, a figure significantly higher than that for readmissions (59 per cent).

Even if all occupational activities were available, 24 per cent of patients and significantly more first admissions (33 per cent) would be unable to participate. Occupational and industrial therapy would still be appropriate for 54 per cent.

Between-hospital Comparisons

Three groups of hospitals were compared: those where the number of new chronics was within one standard deviation of the

mean (20 per 100,000 of the general population) (N = 8) and those where it was more than one standard deviation above (N = 3) and below the mean (N = 3). Patients in 'high occupancy' hospitals, compared with the other two groups, were more often first admissions and had been ill a shorter length of time. They more often had a diagnosis of organic brain disease and on the MRSS they showed less dependency and less inactivity and fewer symptoms. More needed inpatient care.

DISCUSSION

The number of new chronics in 14 Scottish psychiatric hospitals serving a wide range of urban, rural and mixed catchment areas was 20 per 100,000 of the general population. This figure may be helpful in planning new accommodation for such patients but too much attention should not be paid to it in view of the very wide variation among hospitals; in the present study the hospital with most new chronics (29 per 100,000) had almost two-and-a-half times as many such patients as the hospital with least (12 per 100,000).

Examination of the new chronics' characteristics identified two very different populations - those whose current admission was the first to psychiatric care, and those who had had previous admissions. First admissions who have been in hospital more than one year appear to be genuinely 'new' chronics as far as inpatient care is concerned. On the other hand readmissions have certainly longstanding illnesses and have no doubt developed 'cumulative chronicity' (Hassall, 1978); many such patients will make continuous use of psychiatric services, using different facilities at different times.

In the opinion of the consultant and other members of the team responsible for the patient's care 38 per cent of new chronics would not need to be inpatients if other facilities were immediately available, a figure comparable to that found by Mann and Cree (1976). The findings suggest, therefore, that little progress in the past 10 years has been made towards the development of after-care facilities, which are primarily the responsibility of local authority social work departments.

The wide variation in numbers of new chronics between hospitals deserves further comment. The results suggest that staff attitudes may be important. In the opinion of the assessment team, although the degree of disability of patients in high occupancy hospitals was less than that in other hospitals as measured by the MRSS, fewer patients were deemed suitable for discharge. Perhaps the expectations of the assessment team were lower in high occupancy hospitals. This may be due in part to the higher numbers of patients with organic brain disease, but it may also be that less effort at an earlier stage had been put into the rehabilitation of these patients.

This of course is highly speculative, and a more detailed examination of the rehabilitation facilities and staffing in each hospital and its catchment area is planned.

ACKNOWLEDGEMENTS

This survey was carried out under the auspices of the Group for the Study of Rehabilitation and Community Care, Scottish Division, Royal College of Psychiatrists. We wish to thank all participating psychiatrists for their unstinting cooperation.

REFERENCES

Affleck, J. W., and McGuire, R. J., 1983, The Morningside Rehabilitation Status Scale. In preparation.

Hassall, C., 1978, A description of long-term patients from the Worcester case register. In: Report of a Symposium on Chronic Mental Illness. London: Mental Health Division, Department of Health and Social Security.

McCreadie, R. G., Wilson, A. O. A., and Burton, L. L., 1983, The Scottish survey of new chronic inpatients. Brit. J. Psychiat. In Press.

Mann, S. A., and Cree, W., 1976, 'New' long-stay psychiatric patients: a national sample survey of 15 mental hospitals in England and Wales 1972/3. Psychol. Med. 6, 603-16

TRENDS IN PSYCHIATRIC INPATIENT CARE IN THE UNITED STATES

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In the United States, the major policy efforts over the last twenty years have been towards deinstitutionalization and the development of outpatient care, particularly through the community mental health centers. For example, there were 12 times as many outpatient episodes in 1975 as in 1955.

However, inpatient care has also increased over the same time period. Currently more than twice as much money in direct costs is spent for inpatient care as for outpatient care.

In this brief paper, I show a current epidemiological picture of inpatient care and some of the major changes and trends across time. The data that I will present come from a major reanalysis of the national data base for inpatient care in the United States (Kiesler, 1982).

Kiesler and Sibulkin (1983a) describe the distribution of current inpatient episodes in the United States (episodes are defined as residents plus all admissions during the year). State and county mental hospitals in the United States have represented the major target of deinstitutionalization efforts. The latest estimate of inpatient episodes in state and county hospitals was 574,000 in 1977, down from a high of 819,000 episodes in 1955.

At one time, state/county mental hospitals provided the core of inpatient care in the U.S. This is no longer true. Currently there are over 3 million inpatient episodes. The largest subtotal is provided by general hospitals (both with and without a specialized psychiatric unit), which now handle 1.75 million episodes annually.

If one were to ask an educated layman, perhaps even some professionals, what mental hospitalization referred to, he or she probably would respond state and county mental hospitals and private mental hospitals. However, these two together represent only about 25% of the total inpatient episodes in the United States. About 60% of the total inpatient episodes occur in non-specialized, or general, hospitals. Of those, over 70% (and 40% of the national total) are in hospitals without specialized psychiatric care. This customarily would mean ordinary wards, without locked doors, and fewer (if any) psychiatric specialists immediately available.

I note that these latter patients -- those in general hospitals without psychiatric units -- are not well tracked epidemiologically or investigated clinically. They are not surveyed separately and are not usually included in national totals. One further note of interest: community mental health centers have more inpatient episodes than either the veterans administration or private mental hospitals.

In a different paper, Kiesler and Sibulkin (1983b) investigated the rate of mental hospitalization per 100,000 population across time. These data were previously unpublished by the government and were obtained from the National Center for Health Statistics. Previously the usual investigation of rate of mental hospitalizations had no included patients in general hospitals without psychiatirc units. Viewed in that way, the rate of psychiatric hospitalization has been stable across the last 15 years or so.

Kiesler and Sibulkin also investigated the effect on the national rate of including those patients with a primary diagnosis of mental disorder in general hospitals without psychiatric units. Using this statistic as an appropriate total, one finds a linear increase across the years 1965-80. Over those years, there has been a 40% increase in the rate of mental hospitalization nationally, and a 60% increase in the absolute number of cases.

I note that neither of these statistics - rates and episodes - includes psychiatric patients in nursing homes. There are roughly one million of these (Goldman, Gattozzi, & Taube, 1981). We exclude them because it is sometimes difficult to untangle the diagnoses of physical and mental illnesses in these patients, and to detect from records kept whether the patient has primarily a mental or physical disorder. Further, this discussion does not include any secondary diagnoses of mental disorder in the United States. There are roughly one million of these as well. Consequently, one can see that the figures are really quite conservative as national estimates.

It is very important to include in national statistics inpatients

in general hospitals without specialized psychiatric units. If one ignores these patients, then the rate of mental hospitalization in the United States has been very stable over the last fifteen years or so. On the other hand, if one includes them, and I emphasize that they do have a primary diagnosis of mental disorder, then the number of psychiatric inpatients in the United States has been increasing in a linear fashion over the years 1965-80.

In yet a third paper, Kiesler and Sibulkin (1983c) looked at the total number of inpatient days that patients with psychiatric diagnoses have spent in the various sites. The total number of psychiatric days have decreased from 168 million days in 1969 to a little over 95 million days in 1978, a decrease of 73 million days. This drop is more than accounted for by state mental hospitals and the psychiatric hospitals of the veterans administration. State mental hospitals dropped from over 131 million days in 1969 to 51 million in 1978, a decrease of 80 million. Psychiatric hospitals in the veterans administration dropped from 13 million to 3 million, a decrease of 10 million. Thus the two together decreased 90 million, more than the total for all sites considered together. Private mental hospitals (including both for profit and non-profit) remained relatively stable over this time period. All other sites increased.

Considering mental and physical diagnoses together, the total inpatient days for all disorders decreased from roughly 468 million to 381 million over the decade covered. This decrease in total days is often discussed in the press under the general topic of hospital cost containment. However, it is more important to note that 80% of the decrease for all hospital days in the United States is accounted for by the much sharper decrease in psychiatric days. The percentage of all hospital days due to psychiatric disorders dropped from 36% in 1969 to 25% in 1978.

Generally speaking, the number of psychiatric inpatient episodes in the United States has increased, while the number of days spent for psychiatric disorders has decreased. This is primarily due to a shortening of the length of stay in the veterans administration hospitals and the state and county hospitals. The average length of stay in these hospitals is still quite long, 5 and 6 months respectively. We emphasize that the length of stay for psychiatric disorder in other inpatient sites have been stable over the last decade or so.

Conclusions

1.) Although public discussion, particularly regarding deinstitutionalization, has centered on state and county hospitals, these hospitals provide only a small part of the total inpatient episodes currently treated (less than 20%).

2.) There has been a major epidemiological change in inpatient care towards general hospitals, more specifically those hospitals without specialized psychaitric units. Generally speaking, this shift has been little noticed in the scientific literature.

3.) If one includes these cases, the rate of hospitalization has gone up sharply over the last 15 years. If one excludes them, then the rate of mental hospitalization has remained relatively stable over that time period.

4.) Although the total days spent for psychiatric disorders in the United States have gone down, the decrease is more than accounted for by very sharp decreases in days spent in state and county hospitals and veterans administration hospitals.

References

Goldman, H.H., Gattozzi, A.A., & Taube, C.A. (1981) Defining and counting the chronically mentally ill. Hospital and Community Psychiatry, 32, 21-27.

Kiesler, C.A. (1982) Public and professional myths about mental hospitalization: An empirical reassessment of policy-related beliefs. American Psychologist, 37, 1323-1339.

Kiesler, C.A. & Sibulkin, A.E. (1983a) People, clinical episodes, and mental hospitalization: A multiple-source method of estimation. In R.F. Kidd and M.J. Saks (Eds.), Advances in Applied Social Psychology, Vol. 2, Hillsdale, NJ: Erlbaum Associates.

Kiesler, C.A. & Sibulkin, A.E. (1983b) Episodic rate of mental hospitalization: Stable or increasing? American Journal of Psychiatry. (In Press).

Kiesler, C.A. & Sibulkin, A.E. (1983c) Proportion of total hospital days that are for mental disorders. Hospital and Community Psychiatry, 34, 606-611.

INTEGRATION OF IN- AND OUTPATIENT SERVICES

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The separation of the different forms of treatment is one of the problems of psychiatric care that has long remained unsolved. This problem was not really solved by the efforts for deinstitutionalization that can be regarded as the outstanding feature of the sixties and seventies. Despite the creation of the different out-patient services, community mental health centres or half-way institutions, most of these were separate units and each felt responsibility only for the population or patients entrusted to its care.[1]

Even when experts recognized the need for cooperation between the out- and in-patient services, they were unable to overcome the sense of being a separate institution resulting from the independent organizational form. Another subjectiv factor arrosed with the tendency to transfer patients causing problems to another institution when difficulties accumulated /overcrowding in the department or growing pressure from the family for hospitalization of the patient/. The separation was even more marked in Hungary since many professionals wished to see separate departments for the care of psychotics, neurotics, alcoholics and psychogeriatric patients and another organizational framework for patients in day and night hospitals.

In an attempt to overcome this difficulty, efforts were directed at ending the fragmentation found in all areas of health care, the problems caused

by the unnecessary repetition of tests and transfers for therapies. A measure applying to all areas of health care was adopted in Hungary in 1976 and became known as the Integration Act. We have information on similar aspirations in the field of psychiatry, such as introduction of the principle of sectorization in France, the Soviet Union and Italy.[2] These guidelines or papers report on the organization of psychiatric services in the form of larger catchment areas designed to provide care for a population of several thousand. Our intention in the present paper is to show how the facilities of a psychiatric department responsible for the care of a smaller population of 38,000 can be organized in such a way that all forms of care are combined in an integrated unit.

In our conception, integration means a comprehensive care system where all facilities are brought together in the framework of a united department. The department has one physician in charge who is responsible for prevention, out- and in-patient treatment and rehabilitation of a certain population. Therapists and other health workers belong to the same team and any of them can rotate in the system according to a particular plan.

In the field of psychiatry for many years experienced but old-fashioned professionals tried to put obstacles in the way of integration. To overcome these difficulties it seemed practical to organize a model department where we could try to work according to these ideas of integration. For this purpose our unit was established in the National Central Hospital.

The model

We first set up a special form of ward structure which first seemed to be too complicated. Nevertheless, it turned out to be the best solution to meet the needs of our patients.

This structure is briefly outlined in the following. Our institution is located near the centre of Buda /the old part of Budapest/ in a seven-storied hospital, adjacent to which there is a four-floor building where the out-patient consulting rooms are located. Under such circumstances our out-patient service is to be found among the other medical facilities and there is thus no difficulty in access.

The sixth floor houses the acute admissions. There we have four rooms with a total of 14 beds. Our institute has an establishment at a distance of three km from the parent institute. This is a two-storey building, very comfortable, fully equipped and with only 14 beds. We decided not to have medical signs in this building: we do not wear white coats here, we have no surgery and so on. Since we have sufficient space in this setting, we have been able to organize day treatment from 8.30 a.m. to 3.30 p.m. Under such circumstances we can offer nearly a full service for our population. Many experts may think that under such circumstances we will not be able to fulfil our task, since our institute is responsible for a population of 38,000, which means that we have only 7.4 beds for 10,000 persons. This is much below the Hungarian average of 12.8 per 10,000 in 1982. Experiences of recent years /the department began operation in 1977/ show that although utilisation of bed capacity has always been around 100 %, we have never had to refuse admission of a patient in the area we cover, there have never been any complaints about crowding or early discharge and we have not had to record a single case of death due to transfer of a patient from in- to out-patient care because of lack of space. Suitable staffing has been a vital factor in achieving our results.

In terms of staffing, 7 of us are working in the integrated department as psychiatrists and there are 2 psychologists, 1 occupational therapist, 2 administrators and 19 nurses. Only the nurses have a fixed working post. All the other members of the staff follow the patients to the different sections. This means that each patient has the same therapist, physician or psychologist, regardless of whether he is hospitalized or needs follow-up after discharge. With this integrated service we are able to maintain continuous contact with all patients outside the hospital whenever needed, so there is no need to keep them in the hospital too long.

This interchangeable possibility results a very short stay in both in-patient sections. /Table I/ Compared with the Hungarian average stay of 57.1 days, our organization dramatically shortened the duration of in-patient treatment.

Table 1. Length of hospital care

Units	Events	Days	Average
In admission	317	6618	20,88
In rehabilitation	236	5329	22,58
In both	129	4174	32,35
Total	682	16121	23,63

The case register

Our integrated patient care system makes it possible to keep and update a register covering all patients. A running case register may be a useful tool to produce comprehensive information about the changing picture of psychiatric care in a defined area and its effect on the utilization of services.[3] The case registers on which we have information generally cover entire sectors of a given population, while general statistics are based on cases and their unit is the admission or the discharge.[4] Such a statistical approach is able to cover effectively the single admissions, but it is not able to follow adequately the path of the individual patient, e.g. how many times the patient was hospitalized in the given year, how many days he spent on sick leave or when treatment was interrupted and for how long. However, the chronic and fluctuating course of many psychiatric illnesses makes it vitally important to have such information available. The longitudinal picture of the course of illness is of prognostic value on the one hand and, on the other hand the success of a therapy can also be measured by whether the patient spends shorter and less frequent periods in hospital, whether there is a substantial reduction in care and the duration and frequency of periods on sick pay.

I would like to note here that I regard emphasis on relapses as a gauge of the effectiveness of treatment to be a somewhat doubtful or uncertain factor.[5] Data in the literature always regard relapses as an indication of unsuccessful treatment. However, we have found that for an integrated department the

return of a patient is of different significance as the patient never really moves beyond the reach of our care since, under our out-patient follow-up system we keep an eye on the patient for at least 2 years after he is free of symptoms. This is considerably longer than what the statistical surveys regard as a period free of relapses. Moreover, while a patient with symptoms is under our care the therapist is able to observe signs of a relapse much sooner and since he himself will treat the patient whatever the unit involved, he much more readily decides to transfer the patient from an out-patient to an in-patient unit. This decision is always made on the basis of a discussion with the patient and since it will not place the patient in a strange environment, it is much more easily accepted. Thus, although our data do not yet cover a long period, we definitely have the impression that the period of care for patients with relapses can be considerably reduced in this way.

In view of the above problems, there was a need to elaborate a new computerized system able to follow precisely the movement of patients in the different sections of the institute over the entire year.

We devised our own system with the assistance of the Budapest Computer Technology Research Institute, using a GOLEM program on a Siemens 2000 computer. We drew up our own standard case sheet which also serves as a certificate. In addition to the generally used care and treatment data, we also record the capacity for work and the mental state, at the end of each year, using a specially developed code system.

At the present stage of development it is not possible to show the dynamics of our system; for this reason only a few static data are presented. It is hoped that within a few years more conclusions can be drawn from the full system.

I have reported on the attempt to achieve sectorization within the framework of a general hospital responsible for a relatively small population and the standardization of a wide range of forms of care in keeping with the principle of integration. I have also presented our computerized case register elaborated to follow admissions and the fate of patients treated. The present static indicators will later provide valuable data on the dynamics of organization and care.

References

1. A. Becker, Can the community mental health center replace the mental hospital? in: "Aspects of Community Psychiatry", J. Divic, M. Dinoff eds., The University of Alabama Press /1978/.
2. WHO Working Group, "Changing Patterns in Mental Health Care", Regional Office for Europe, EURO 25 Copenhagen /1980/.
3. A. Marioni, E. Torre, G. Allegri, M. Comelly, Lomest psychiatric case register: the statistical context required for planning, Acta psychiatr. scand. 67:109 /1983/.
4. J. A. Baldwin, J. Leff, J. K. Wing, Confidentiality of psychiatric data in medical information systems, Br.J. Psychiatry 128:895 /1976/.
5. E. M. Neuhring, J. H. Thayer, R. A. Ladner, On the factors predecting rehospitalization, Adm.in Mental Health 7:247 /1980/.

COMPARATIVE APPROACHES TO INITIATING MENTAL HEALTH CARE IN PRIMARY CARE SETTINGS

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INTRODUCTION

The idea to organize a symposium on comparative approaches to initiating mental health care in primary care settings came from our wish to add to the visibility that mental health in primary care ought to have. Most of the patients who suffer from mental disorder as well as others who could benefit from the application of mental health skills in the resolution of their worries, anxieties or other problems of that nature are found in primary care. They are often not recognized and rarely given appropriate treatment. A number of studies have found this to be true both in developing and in developed countries.

A second reason for bringing together the authors of the papers in this symposium was that it is impossible to imagine the provision of mental health care through any other channel but that of primary care. Even the richest countries cannot afford a different model. At present specialist services cater to a small proportion of the people with mental disorders, even in countries where the tradition of psychiatric care and resources for such care are most abundant. In developing countries the situation concerning resources is incomparably worse and the needs - it has been shown by a number of studies - are no smaller than those of industrialized nations.

Of the eight papers brought together in this volume, three deal with methodological considerations, two with personnel and their roles, and two with settings in which care is provided. The final paper is a review of barriers to provision of care aiming to further underline the fact that the papers in this symposium

represent a selection of issues, problems, solutions and approaches: a selection rather than any attempt at the comprehensive description of a vast universe of things achieved and things to do.

In the initial three papers, methodological considerations are the primary focus. Burns and Burke analyze the problems using findings from multiple research efforts over the past several decades. Physician characterists, patient behaviour, the nature of psychiatric illness, and service system characteristics are identified as major elements of any approaches to improving mental health practices in the primary health care setting. Following this methodological overview, Clare and Goldberg in the following two papers focus respectively on different aspects of the roles of social workers and family doctors. While Clare looks at how social workers can assist in the provision of services through collaboration with the general physician, Goldberg points out how the use of screening questionnaires by family doctors can expand their capacity to identify and treat those with minor psychiatric illness.

The following two papers address the problem from both a system and situation-specific perspective, namely an urban ghetto in Manila and a rural "sub-province" (block) in India. In these two vastly different cultures, programmes were designed which increased accessibility to the residents of previously unavailable mental health care using health care personnel whose prior knowledge of mental illness and interest in mental health care were limited. Ignacio in Manila and Wig in Raipur Rani describes the techniques used to accomplish these programmatic interventions.

Finally, Beigel has reviewed a multiple number of efforts to introduce mental health care through primary settings and identified significant barriers which must be overcome if these limited efforts to introduce mental health care though primary care settings are to be expanded and to be more effective.

As stressed, above, this is not a comprehensive review of issues concerning mental health in primary care: rather it is intended as a stimulus for thinking and debate and a reminder of where the real focus of mental health work lies; also it is a tribute to some of the outstanding work that has been done in this field.

MENTAL HEALTH CARE - THE ROLE OF NON-MEDICAL GOMMUNITY INSTITUTIONS: A PHILIPPINE EXPERIENCE

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Mental health care relies heavily on the network of relationships that exist within the immediate and wider social group. When mental illness occurs, such care is influenced by the perceptions and reactions of the patient's family, those of the community at large as well as specifically those of relevant community agents, health and social workers, religious leaders, the police, etc., whose interventions need to be mobilized. Such a network of human relationships is crucial in the face of manpower, financial and attitudinal constraints to mental health care presently existing in developing countries. In these countries, it has been the prevailing opinion that it is more appropriate to mobilize existing community institutions to respond to the mental health problems of the community members rather than initiate new and specialized ones. To accomplish this, the community must be able to identify not only those institutions which can play a significant role in the development of a support network for mentally disturbed individuals, but also identify strategies to mobilize the specific institutions and their resources toward addressing the mental health problems of the community members as a priority. It is vital that this is recognized and accepted by existing care givers entrusted with mental health care in the community.

A WHO collaborative study was undertaken in seven developing countries (Brazil, Colombia, Egypt, India, Philippines, Senegal, Sudan) to determine the feasibility of undertaking mental health care in primary health care. Among the objectives of the study is to

develop and evaluate ways of stimulating the community's understanding and response to the problems related to mental disorders. The study has shown that the integration of mental health care in primary health care can be feasible through the training and reorientation of the existing health workers. Such training will allow them to develop the competence and skill to detect selected priority mental problems and provide simple management at their level of care. This also includes their recognition of the role of non-medical community agents (the police, social workers, religious and political leaders, teachers, etc.) in mental health care and their willingness to work with or through them. Traditionally, existing health workers remain in their health stations and are unaware of the actual life conditions of the people they serve as well as the involvement of other agents in handling life problems. Health workers have been quite isolated from the community at large, unable themselves to participate in the network of existing relationships oftentimes crucial for their effectivity as care givers in the community they serve. This includes their inability to understand and relate to the families of the patients who come to consult them.

This paper will present results from the Philippine study relevant to the issues regarding the integration of mental health care in primary health care through the mobilization of existing non-medical community institutions by the health workers, following their training. The study was undertaken in a deprived urban area in Sampaloc, Manila covering 75,000 people and served by three health centers. Each center has a physician, nurse, midwife and dentist.

Methods:

Baseline information was gathered. Data to be presented here will cover those regarding the awareness of health staff, regarding the role of the family and other community agents in daily health care in the community. The reaction to mental illness in the community served by these health centers were ascertained through key informant surveys. The survey includes the presentation of vignettes describing psychiatric disorders.

This information served as the basis for planning mental health care in the community. Central in this plan is a program for training these health workers who will be expected not only to diagnose and manage mental disorders, but also, who will mobilize existing community institutions to maximize this care.

Repeat observations were made 18 months after this training to gather the same information as in the baseline data to assess how much this training had modified some of the health worker's knowledge and attitudes about the role of other community agents in mental health care.

Results:

Table 1. Types of mental health work advocated by health workers

	Before (%) n = 12	After (%) n = 12
Preventive work-concerning care of young children	13.3	93.3
Cooperation with local community leaders	6.7	100
Education on dangers of alcohol/ drugs	6.7	20.0
Support to patient and family during life crises	6.7	100
Support to families with mentally retarded children	0	6.7
Deal with psychiatric emergencies	0	40
Regular treatment for patient with epilepsy	0	6.7
Regular treatment for chronic psychotic patients	0	50.0

Significant changes have been shown in the health workers opinion in such activities as cooperation with local community leaders and support to patients and families during life crises.

Table 2. Treatment choice: Percentage of key informants opting for modern health services for selected symptoms

	Baseline n = 98	Repeat n = 102	Changes
Somatic conditions			
Fever	86.7	80.4	
Pregnancy	85.7	98.0	
Skin diseases	77.6	81.4	
Cough	81.6	84.3	
Blood in urine	76.5	79.4	
Somatic combined	81.6	84.7	
Neuropsychiatric conditions			
Sleeplessness	51.0	53.9	
Excitement	57.1	55.9	
Possession	1.0	0.98	
Strange, unpredictable behavior	30.6	56.9	X
Convulsion	72.4	89.2	X
Neuropsychiatric combined	42.2	51.4	X

The availability of local treatment by existing health workers for selected psychiatric problems has been accompanied by significant shifts in community attitudes. There has been an increased preference for using the health center in the care of strange, unpredictable behavior and excitement. In addition, a more optimistic attitude has now been developed regarding the social disabilities of acute psychoses.

The repeat observation has also indicated greater freedom and openness in discussing mental health problems in the community - including mental disorders - with the family and significant members in the community who have now started to identify cases, they initiated the whole range of processes in providing treatment by securing the necessary medications as well as taking part in bringing the patient otherwise hidden by his family in for treatment.

Training of health workers

How were the health workers trained to mobilize the non-medical community agents to participate in mental health care?

As the health workers gained some degree of competence and skill in detecting selected mental problems as well as providing simple management, they gained a more positive attitude towards mental health care. More participation in handling these problems was seen. As they increased the frequency of visiting their patients in their homes, they started to know and relate to significant people in the community. Soon, they were being asked to lecture groups in the community about mental health problems. As these evolved they started to appreciate the role of other community agents in health care including mental health care.

For the purpose of their training, the health workers were oriented to the other community groups and resources and their roles were clarified. What was continually emphasized was their need to understand their partnership with these groups in the delivery of health care. The various community groups were identified as social (including family, religious and traditional healers), political (including community-based political units) and groups which also served as potential job resources. A more active collaboration with these groups was encouraged and it is hoped that examples of this joint work will be presented to help illustrate contributions towards the creation of a mental health service delivery growing out of, but remaining within, existing community institutions.

The most ubiquitous social institution which can be identified in any community is the family. This is particularly true in developing countries where housing shortages, among other economic disadvantages, often result in multiple families living withing the same housing unit or a significant extended family residing together. In Sampaloc, an area of 75,3888 people in the third district of Manila, it is not uncommon to find as many as 48 people from as many as eight families residing within a single housing unit or about eight persons per room in the unit.

Consequently, the extended family or the multi-family unit is a primary resource for enhancing the optimal performance of the individual who is mentally disordered. Furthermore, with the frequent presence of many family members in or near the home because of the absence of adequate job opportunities, many individuals are present on a continuous basis to act as surrogate parents, siblings or helpers, especially for mentally disordered individuals. Two examples of how "mothers" were utilized as important care providers given within this developing informal mental health care delivery system will serve to illustrate how the family, as a social institution, played a significant role in the development of mental health services.

Mothers' classes have been organized at the health center. These are composed of mothers who would ordinarily come to the well or sick baby clinics at the health center. The classes include instructions on immunization, proper nutrition and home sanitation. As discussion progress, the mothers are given the opportunity to become aware of the various sources of human stress and what possible strategies within their homes or communities they can use to minimize mental health problems. As a result, they have started to become sensitive to the problems of their children; as such they have been more able to detect whenever a member of the family is in trouble and to refer that person to the appropriate service when necessary.

Since the majority of mothers are at home and therefore in the community the whole day, they were organized as a group to establish and maintain health-related services. In this particular area, professionals have found it difficult to maximize the involvement of mothers in the community because it required a relatively new role. What was found, however, was that these "mobilized" mothers in the community could initiate and/or undertake activities to augment the family's meagre income thereby improving their access to resources, hence improving to some degree mental health as well as providing surrogate services to a family currently faced with an illness or a crisis.

The contribution of the religious units in the community has also been recognized. The Philippines is a predominantly Catholic country and the priest is held in esteem as the spiritual leader of the community. He has been regarded as the legitimate authority to provide care for many human problems and is correspondingly sought out by the members of the community. The social transaction between the spiritual leader and community members is held in strict confidence, making the priest even more acceptable as a resource for assistance with mental problems. Therefore, in initiating a community-based mental health service delivery system, the Church has been recognized as an important resource and its district participation encouraged in solving these significant community problems. The Church has undertaken social action activities and this has been a tool to promote the mental health status of the community.

The parish priest of a Catholic church near the health center has become the Chairman of the center's community activities. Through his initiative, regular meetings of the community have been held in the parish to handle such problems as drug abuse, alcoholism, the chronic mentally ill patient and the runaway child. It has also not been uncommon for the priest to intercede with family members who resist treatment and in most cases, he succeeds. He also provides participation in mobilizing the other members in the community to help families in distress and crises.

On another level, religious institutions often interface with health care through the role of the traditional healer - a religiously derived cultural phenomenon. In the Philippines individuals still rely frequently on the intervention of traditional healers rather than turn to practitioners of more western types of health care, especially mental health care. The health workers are aware of this but have been faced with the dilemma of whether to acknowledge these healers who they know exert a palpable influence on the people, especially in matters of health, and run the risk of rebuff for not being modern. During their training, they recognized that they need to establish some degree of relationship with these healers, since it has been the prevailing opinion that this may be important in mental health care.

Since the political unit within the community is the only one vested with the legitimate exercise of power and authority, its role in the management of health problems, including mental health problems, was emphasized. This was considered vital since traditionally health workers would be isolated from this important unit in the community. They have failed to recognize that the political unit in the community can create, and support (sometimes better than other groups in the community) new community decisions, practices as well as structures designed to augment prevailing meagre resources.

Awareness of mental health issues was initiated in our study area through the mobilization of the lowest political unit in the community - the barangay. Through participation in the barangay health council, the barangay Chairman facilitated the development of services through mobilization of key informants who provided the necessary data for the identification of mental health needs and resources. These included the representation by the barangay of those who needed economic assistance either directly or through the formation of income-generating activities participated in by members of the community. In addition, one of the barangay chairmen in the study areas became actively involved in mental health care when he experienced the significant help extended by the staff in the health center to his daughter who is a chronic mentally ill patient. Through his efforts, other members of the community became formally organized in providing a sense of neighborliness: this proved subsequently crucial in extending the necessary social support and material resources to distressed families of other patients. On a more informal level, reaching out to the community's leadership structure provides a pathway toward overcoming stigma through the involvement of these leaders in addressing those problems. This leadership has been particularly crucial, especially in developing countries because here the leader is central to community life. What he thinks and how he thinks greatly influences other members of the community. This includes the community prevailing concepts about health and illness and where help can be derived.

The actual experiences of participating in various community groups have helped existing health workers to recognize that the existing limited resources for mental health care can be met by consciously coordinating community participation. As the health workers have started to see that in the community where they work (and this is probably the case for most developing countries) it is ar more common to see individuals with problems in all areas of their lives rather than see individuals with problems limited to one of them, they also started to see that handling those problems singly or separately would be a serious mistake. They have also started to see that they need to have a complete picture of a patient's needs so that they can combine available resources, maximize the impact of such services and possible reduce the overall cost. More importantly, they have started to appreciate that non-medical agents in the community can have valuable participation in this type of health care.

It has also become apparent that any strategy to address mental health problems in a developing country offers a unique opportunity to focus on the need for this type of community group cooperation and complementation since mental health problems themselves often illustrate very effectively the inter-relatedness between the institutions described and how breakdown within them can lead to emotional disorder.

REFERENCES

1. Agbayani, B., M.D., Damian, A., M.D., and Mendoza, C., (ed), Proceedings and Selected Writings on Paraprofessional Health Workers Manpower Development, Mozar Press, Manila, Philippines, 1975.

2. Argyle, M., (ed), Social Encounters: Readings in Social Interaction, Penguin Books Ltd., Harmondsworth, Middlessex, England, 1973.

3. Arieti, S., Caplan, G., (ed), American Handbook of Psychiatry, Vol. II, Basic Books Inc., New York, U.S.A., 1974.

4. Climent, C., Diop, B.S.M., Harding, T., Ibrahim, H.H.A., Ladrido-Ignacio, L., Wig, N.N., "Mental Health in Primary Health Care". WHO Chronicle, 34: 231-236, 1980.

5. Eaton, J., (ed), Institution Building and Development, Sage Publication, Beverly Hills, London, 1972.

6. Ladrido-Ignacio, L., "The WHO Collaborative Study on Strategies for Extending Mental Health Care in General Health Care" the Philippine study, Report to the Regional Coordinating Group Meeting, WHO Western Pacific Region, Manila, Philippines, 25 April - 1 May, 1979.

7. Ladrido-Ignacio, L., "A Historical Perspective of the Philippine Community Mental Health Movement", in Today's Priorities in Mental Health, Symposia Specialists, Inc., Florida, U.S.A., 1978.

8. Jocano, F.I., Slum as a Way of Life, University of the Philippine Press, Q.C., Philippines, 1975.

9. Kiev, A., Transcultural Psychiatry, Penguin Books Ltd., Harmondsworth, Middlessex, Philippines, 1972.

10. Wig, N.N. et al. Community Reactions to Mental Disorders, Acta Psychiatric Scandinavia, 1980, 61, 111-126.

DELIVERING MENTAL HEALTH CARE IN RURAL PRIMARY CARE SETTINGS: AN INDIAN EXPERIENCE

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INTRODUCTION

In the last two decades there has been a major shift in the organization of health services all over the world. With the growing awareness of the health needs of people, the provision of low-cost effective health services has become the prime concern of health professionals in every country. In the developing countries of Asia and Africa, planning of health services for a vast population poses many problems. How does one provide basic health care to the people where the fundamental problem is one of a rapidly increasing population and limited resources. Approximately 70% to 80% of the people live in rural areas scattered over thousands of miles, without access to the cities and hospitals, constrained by forces of terrain and weather, and hampered by limitations of money and time. Despite these many problems, India has accepted the Primary Health Care as the National Policy and has developed an infrastructure of health services through primary health care centres. Correspondingly, there has been a consistent effort to decentralize the health activities

and services. Thus, the integration of mental health services within this framework of primary health services has become a necessary concern of mental health professionals in India. Today, in India, as in all other developing countries, mental health has become much too important to be left to a handful of psychiatrists who are all confined to big cities. The pressing need of the day is to develop newer models for prividing basic mental care to our rural populations.

Certain problems are inherent in the Western systems of health care delivery. Concentration of services in urban areas, and the emphasis on specialization and curative care, will only widen the gap that exists today between the rich and the poor. It is in this context that the recommendations of the World Health Organization Expert Committee on Mental Health (1975) takes on a special significance. The approach to the delivery of mental health services in the community must be through adequately trained non-specialist health workers, supported by specialists.

RECENT DEVELOPMENTS IN COMMUNITY PSYCHIATRY IN INDIA

Following this important landmark in the history of planning for mental health, the Community Psychiatry "movement" began in India with two major experiments, one in Chandigarh, in the North (Harding et al., 1980), the other at Bangalore in the South (Kapur, 1975). At the National Institute of Mental Health and Neurosciences, Bangalore, a model centre for community psychiatry training was developed in the mid seventies. Over the last seven years a number of research projects have been carried out in this centre, these include training programmes in mental health for health workers and doctors at the primary health care levels, the development of a model for the delivery of mental health services through the trained personnel, and evaluation of different training techniques and case identification methods (Isaac et al., 1983). Today this centre is actively involved in the training of general practitioners, State Government doctors, school teachers, and other personnel involved in mental health.

WHO STUDY AT RAIPUR RANI

At the Postgraduate Institute in Chandigarh in the North a project was launched in 1975 in collaboration with WHO as part of the International Collaborative Study "Strategies for extending mental health care" in seven geographically defined areas in Brazil, Colombia, Egypt, India, Philippines, Senegal and Sudan. Raipur Rani, a rural block situated 35 kilometres from Chandigarh with a population of about 90,000 and with over 100 villages, was selected for the study. Baseline studies on prevalence and attitudes towards mental disorders indicated that large numbers of mentally ill residing within

the community were not receiving adequate medical attention (Srinivasa Murthy et al., 1978). Most of the health personnel involved in primary health care were unaware of the principles of identification and management of such persons. A screening of the outpatient population at the Raipur Rani Primary Health Care Centre also highlighted the inability of the Centre to cater to the needs of the mentally ill. At least 30% of the adults and 20% of the children who attended this rural clinic had some psychiatric symptoms. Many of the severely mentally ill were not being brought to the PHC because of the general belief that the PHC is not equipped to handle such problems. Most of them went to traditional healers for treatment (Wig et al., 1980).

The first important step in the organization of mental health services began with the setting up of a rural Mental Health Clinic, once-a-week at the PHC premises, manned by non-psychiatric research staff members and supervised by the psychiatrist. This clinic provided basic mental health care to patients of acute and chronic psychoses, depression, epilepsy and mental retardation. These priority conditions were chosen primarily because of the felt needs of the community and also because relatively clearer guidelines were available for their management.

As the number of patients attending this clinic steadily increased the time now came to further "decentralize" services by training health workers to manage patients at the subcentres. PHC doctors, health supervisors and multi-purpose workers underwent a suitable task-oriented training programme. The emphasis was on the early recognition, prompt diagnosis and management of priority conditions with the use of only three psychotropic drugs, viz: chlorpromazine, imipramine and phenobarbitone. At least half of the expected prevalence of cases were identified by the end of the project. Most of these patients were being handled independantly by the health workers at their respective sub centres, with only supportive help from the research staff who visited them once a week. In fact the majority of the psychotics and other severely mentally ill persons were receiving continuous long-term treatment right in their homes.

The clinic at Raipur Rani was now being visited by patients from far off places outside the study area. The follow-up attendance was particularly remarkable with an average of five visits for over 34% of the patients. Many patients would wait alongside the main road to receive their medicines directly from the staff as they travelled down to Raipur Rani. The utilization of the services in the clinic gradually displaced the doubt that there were no mentally ill persons in the area, as well as changed the belief that the common man does not readily accept modern methods of treatment. From an initial handful of cases, by the end of the third year, about 50 to 100 patients were attending the clinic every week. Over 500 cases had been registered in the clinic.

The success of this programme was amply demonstrated, when the local Elders of Raipur Rani got together to form a "Mental Health Association" with a commitment to ensure that every mentally ill person within their community received the benefits of modern medicine at a nominal cost. Other important highlights of this research project have been the standardization of screening instruments, preparation of health education material, and a Manual of Mental Disorders for Primary Health Care Personnel (Wig et al., 1981). This manual has been the culmination of a rewarding experience in the field of community psychiatry, as well as the beginning of an era where the designing and evaluation of teaching manuals for non-professionals has become a national priority.

THE CURRENT SITUATION IN INDIA

What has been the impact of these two major experiments on the national scene? In the field of mental health, in the wake of these two experiments, many more such programmes have been initiated in different pockets of the country, programmes where the training of primary health care personnel is being incorporated in field projects. The Indian Council of Medical Research has played an important role in initiating and funding such research projects by providing a forum where a healthy communication of new ideas can take place. Special emphasis has been placed on the exposure of other mental health professionals to such pioneering experiments in the community. Following a training programme in the delivery of mental health services for mental health professsionals, which was conducted by the ICMR in 1981, many of the trained professionals are now engaged in important research projects in their respective institutions (ICMR, 1982). While one professional is actively involved in the organization of rural mental health services for the entire region of his state, others are busy in evaluation studies, designing of manuals and record-keeping procedures. Today such programmes are viewed seriously and are receiving priority treatment in research.

The major breakthrough in the efforts of the mental health professionals and the ICMR has been the formulation of a National Mental Health Programme. Prepared after the deliberations of top psychiatrists from all parts of the country in a number of forums and workshops, this programme outlines a proposal for the implementation of a mental health care delivery system throughout India. Integration of mental health with basic health services through appropriately trained primary health care personnel is the main theme of the National Mental Health Programme. For the first time in the history of independent India, mental health was discussed and accepted as an important health need in the deliberations of the Central Council of Health in August 1982. Psychiatry has indeed travelled a long way, along the dark corridors of the mental institutions of the forties and fifties, through the open doors of the general hospital psychiatry units of the sixties and seventies, and finally, out into the fresh air of the ever-expanding rural mental health clinics of today.

FUTURE NEEDS

It is therefore now time to evaluate what has been achieved over the past three decades. As a leading nation of the third world countries India has a responsibility not only to itself but also to other developing countries. Experience from the past has only too clearly demonstrated the importance of evaluation studies in the implementation of any nationwide programme. Before any proposal for mental health care can be translated into action at the national level, the current models of rural mental health services need a closer look. Cost benefit analyses are needed to keep our priorities in line with the nation's immediate and long-term needs. Are we justified in proposing primary mental health care as opposed to institutional and specialised care? Cost effective studies of how to achieve a given level of performance at the minimum cost is probably the most important issue in any developing country. We have to decide which model of mental health care is the most effective and the least expensive.

Today in India mental health professionals are faced with many doubts and important questions. Answers to these questions are essential for the success of future programmes. While experimental research projects have shown that the delivery of mental health care through primary health care systems is feasible, we still do not have clear answers to questions such as what drugs to use, how much, and for how long. What are the minimum criteria for the diagnosis? What are the exact referral criteria? and so on. Again, many others would seriously doubt whether we are ready to shoulder the responsibility of training large numbers of primary health care personnel scattered all over the country. Even amongst the mental health professionals of our own country many differing views are expressed. However, those who have personally worked in a rural setting are convinced that in spite of the immense difficulties in this field, integration of mental health services at the primary care level is perhaps the only way by which we can make available the benefits of modern psychiatry to the countless millions of rural population of developing countries.

REFERENCES

Harding, T. W., De Arrango, M. V., Baltzar, J., Climent, C. E., Ibrahim, H. H. A., Ignacio, L. L., Srinivasa Murthy, R. and Wig, N. N. (1980), Mental disorders in primary health care, Psychol. Med. 10: 231

Isaac, M. K., Kapur, R. L., Chandrasekhar, C. R., Kapur, M. and Parthasarathy, R. (1983), Mental health delivery through rural primary care - Development and evaluation of a training programme. Indian J. Psychiat. 24: 131

Kapur, R. L. (1975), Mental health care in rural India: A study of existing patterns and their implications for future policy, Brit. J. Psychiat. 127: 286

National Mental Health Programme (1982), mimiographed copy can be obtained from Directorate of Health Services, New Delhi, India

Strategies for research on mental health (1982), Indian Council of Medical Research, New Delhi, India

Srinivasa Murthy, R., Kaur, R. and Wig, N. N. (1978), Mentally ill in a rural community: Some initial experiences in case identification and management. Indian J. Psychiat. 20: 1

Wig, N. N., Srinivasa Murthy, R., Harding, T. W. (1981), A model of rural psychiatric services - Raipur Rani experience, Indian J. Psychiat. 23(4): 275

Wig, N. N., Suleman, M. A., Routledge, R., Srinivasa Murthy, R., Ignacio, L. L., Ibrahim, H. H. A. and Harding, T. W. (1980), Community reactions to mental disorders - a key informant study in three developing countries, Acta Psychiat. Scand. 61: 111

World Health Organization (1975), Organization of mental health services in developing countries. Technical Report Series, No.564 WHO, Geneva, Switzerland

DELIVERING MENTAL HEALTH THROUGH PRIMARY HEALTH CARE: THE LESOTHO EXPERIENCE

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INTRODUCTION

The Kingdom of Lesotho is an independent country which is completely surrounded by the Republic of South Africa. It covers an area of 30,350 square kilometres and has a population of approximateley 1.3 million people.

It is a very mountainous country with the peaks of Maluti and Drakensburgh mountains reaching up to an altitude of 3350 metres above sea level. Allweather roads are few and mainly connect smaller towns to the capital town of Maseru. But about 90 percent of the population lives in rural areas (Potloane, 1979). Access to rural health centres is difficult an in most places is only possible by donkey, horse, on foot, or four-wheel drive vehicles.

Mountain paths or gravel roads are traversed by numerous streams or rivers. These carry large torrents of water during summer months and since most of them lack good bridges, they are frequently impassable - isolating hundreds of people in remote villages.

PSYCHIATRIC INFRASTRUCTURE

Like most countries in Africa, there is only one psychiatric hospital. This has a maximum bed capacity for 120 in-patients. In addition to this, there are nine Mental Health Units each with an in-patient bed capacity 16-20 patients attached to each Government Hospital located in the nine major district urban centres.

Because most patients are admitted and treated in the

district Mental Health Units, the daily average bed occupancy in the psychiatric referral hospital is approximately 80 in-patients. As more and more patients become managed and followed-up by rural-based Nurse Clinicians and Village Health Workers, the number of hospitalized patients is bound to become increasingly less.

There are only two psychiatrists in the country, one of whom is the wife of an expartriate engineer and may leave the country any time. The prospects for another indegenous psychiatrist in the near future seem very meagre indeed.

There are currently five trained psychiatric nurses in the country four of whom are working in the psychiatric referral hospital. The fifth one is based in a district Mental Health Unit. The rest of the Mental Health Units are manned by general nurses who have only had in-service courses in psychiatry and psychiatric nursing but most are keen and competent.

The two present psychiatrists pay regular consulative visits to most of the upcountry Mental Health Units to review treatment for in-patients, conduct out-patient clinics and to support and often train nurses based in these units.

Recently some of the nurses based in the Mental Health Units have also started paying consultative visits to outlying rural health centres to provide similar services to their colleagues based in rural health centres and clinics.

NEW STRATEGIES FOR PROVIDING EFFECTIVE HEALTH CARE SERVICES IN LESOTHO THROUGH THE PRIMARY HEALTH CARE APPROACH

The Government of Lesotho has adopted the Primary Health Care approach as the only feasible means by which the social objective of Health for All by the Year 2000 can be achieved. All health services (including mental health services) are being decentralized and there are concerted efforts to motivate members ot the communities to actively participate in various health activities.

In line with the recommendations of the W.H.O. Expert Panel on Mental Health in Africa (WHO 1979), the decentralization of mental health services and integration of many mental health activities into general health services has been accompanied by continual retraining of existing general health workers to provide mental health care within the framework of Primary Health Care.

Also since 1977 all student nurses, midwives and trainee nurse assistants receive substantial mental health training designed to equip them with specific skills and knowledge that

will enable them to provide mental health care as part of their day-to- day functions.

One sub-objective of this training and reorientation process is the definition and demarcation of specific tasks for each category of health personnel according to competencies and level of training. The process is not yet complete and there are still many hurdles to overcome, but the established framework for mental health services in Lesotho envisages four operation levels:

1) The most peripheral health workers in Lesotho are the Village Health Workers (VHW's). These are rural people chosen by members of their own villages and trained by health workers and others to motivate communities in their respective areas to prevent specific health problems e.g. tuberculosis, diarrhoea and vomiting in children, alcohol and drug abuse etc. and to identify and refer patients suffering from specific health problems (including mental health problems). Their functions also include follow-up and supervision or support of patients who are undergoing treatment in their villages e.g. ensuring that tubercolosis and mentally ill patients take their prescribed drugs regularly and attend follow-up clinics.

   The training of Village Health Workers (VHW's) is coordinated by the area nurse clinician (see next level below) and public health nurses and in their respective areas. They are expected to collaborate with local chiefs, the traditional healer, public workers from other ministries e.g. agricultural extension worker and take an active part in the activities of the Village Development Committees.

   A modular approach has been adopted for the training of VHW's and the mental health module which has been developed in collaboration with psychiatrists and psychiatric nurses are taught by mental health nurses. Topics covered include:

   - Identification of mentally sick persons in the community (how do you know that a person has a mental illness).

   - What causes mental illness in Lesotho

   - How a mentally sick person can be helped by members of the family, frineds and others in the village.

   - How the VHW can help so the people do not get mental illness.

   - How the VHW can help the mentally sick person to help himself.

2) The second operational level consists of rural health centre personnel is headed ba a Nurse Clinician and may include other nurses, midwives and sanitarians collaborating in various health promotional, preventive and curative activities.

Nurse Clinicians are basically trained nurse-midwives who after some experience in rural health centres undergo a 12 months intensive course designed to equip them with predetermined medical skills and knowledge to enable them to diagnose and treat common health problems in rural communities of Lesotho. It has been estimated that they can treat 90 percent of health problems in the community (including mental health problems) and only refer very serious cases to the doctor at the district hospital. They are equivalent to medical assistants in other parts of Africa.

Mental health constitutes one of the major modules in the training of Nurse Clinicians. The emphasis is on the teaching of relevant knowledge and skills to enable them identify and manage priority mental health problems in her "catchment area" and to support and follow-up mental patients within the context of the family and mobilizing community support for the patient. Seriously disturbed patients who cannot be cared for at home are supposed to be referred to the Mental Health Units in their respective districts.

Nurse-Clinicians are also expected to collaborate with various community leaders, other rural-based government workers and VHW's to promote community health, prevent diseases and to get assistance in treating and rehabilitating sick persons in the community.

Unfortunately the linkages between all rural Health Centres and Mental Health Units have not yet been fully established.

3) Mental Health Units:

Nurse Clinicians and other nurses bases in rural health centres are expected to cooperate fully with the nurse at the district Mental Health Unit and to cross-refer patients to each other for treatment or follow up.

Patients in the community who are severley disturbed and need temporary hospitalization are referred to the Mental Health Unit until they are well enough to be managed and followed-up at home. After discharge they can be followed-up by the Nurse Clinician and supported by the Village Health Workers.

The Mental Health Unit is supposed to provide more specialized nursing care and ideally should be staffed by a qualified

psychiatric nurse. But at present only one of the nine units has a qualified psychiatric nurse. However, it is planned that in future this will be so.

Ideally, each patient discharged from the Mental Health Unit should be referred to the Nurse Clinician or general nurse at his/her nearest health centre for follow-up. But we do not yet have sufficient Nurse Clinicians to cover the whole country and some nurses based in rural health centres have not yet received reorientation teaching in Mental Health.

4) The National Psychiatric Referral Hospital

According to Lesotho Mental Health Law (1964) patients admitted to a Mental Health Unit must not exceed 8 weeks in the unit. After that they must either be discharged or transferred to the main psychiatric hospital. This provides opportunity for more specialized treatment at the psychiatric hospital.

The psychiatric hospital therefore is the fourth level of psychiatric services and this is in line with the recommendations of the W.H.O. Mental Health Expert Panel in Africa (W.H.O. 1979).

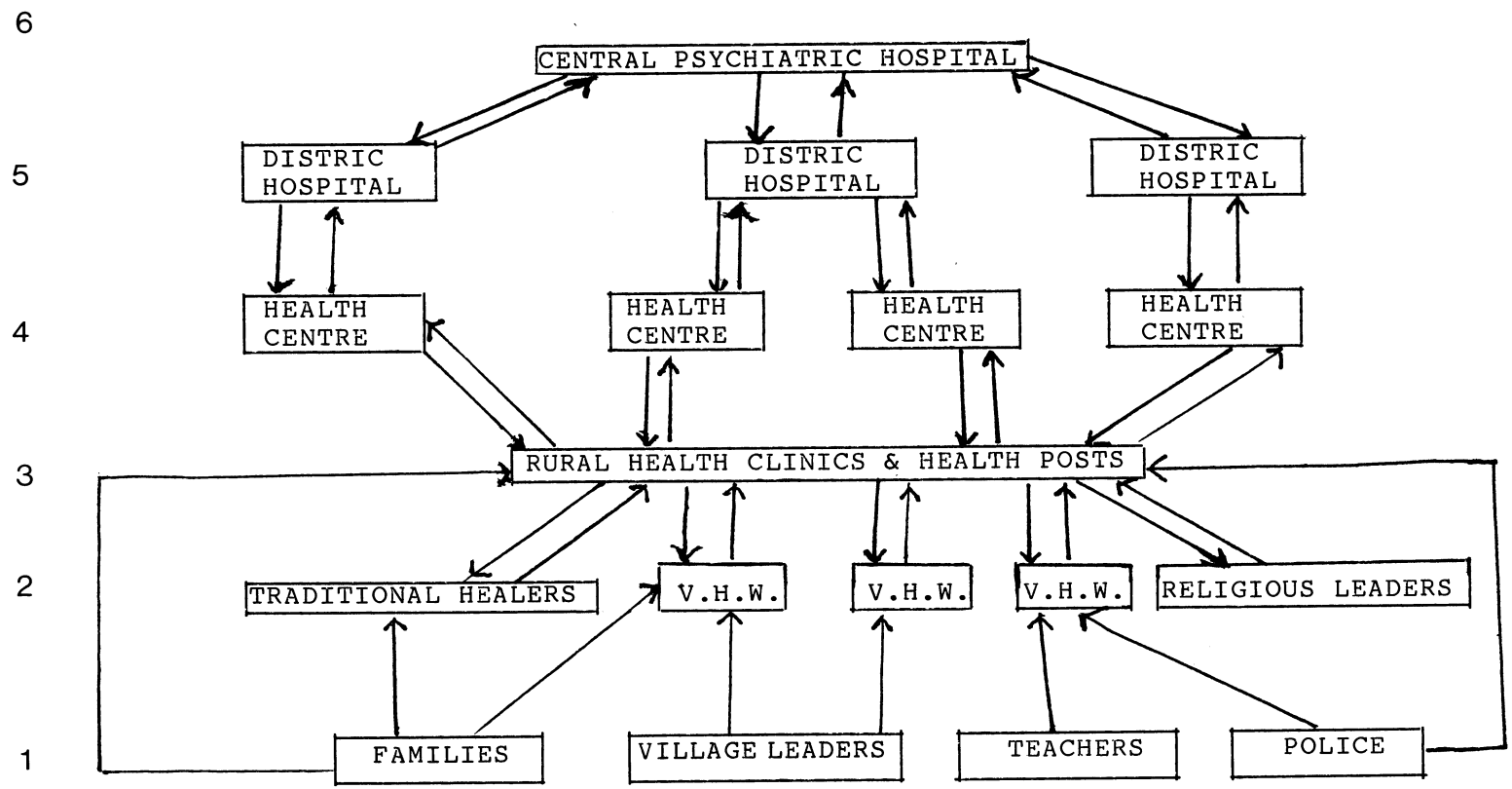
Patients who are very sick and need urgent specialized treatment such as Electro-Convulsive Therapy and others are admitted directly to the hospital either from the health centres, private doctors, or other hospitals. The psychiatric hospital has an established list of 12 psychiatric nurses, but so far most of them are not qualified psychiatric nurses.

CURRENT PROBLEMS OF DELIVERING MENTAL HEALTH THROUGH PRIMARY HEALTH CARE IN LESOTHO

1) The main obstacle to the effective implementation of this strategy so far are the still widespread negative attitudes to mental health which still exist among some key people in some sections of the community - including some influential doctors at district hospitals (who are also in charge of mental health units and outlying rural health centres).

2) In some cases the health professionals have not done enough to effect the full link-up of the four operational levels. Some nurses based in Mental Health Units are still unable to cooperate fully with the outlying health centres - thus causing a dislocation in this vital chain of referrals and cross-referrals.

This is not only due to their own unwillingness to do so, but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RURAL HEALTH CLINICS & HEALTH POSTS
TRADITIONAL HEALERS
V.H.W.
V.H.W.
V.H.W.
RELIGIOUS LEADERS
FAMILIES
VILLAGE LEADERS
TEACHERS
POLICE

many of their colleagues are not yet fully sensitized to this new approach.

They are still regarded by many nurse administrators and others as custodians of "mad people" in these units and not expected to go beyond that into the community. Some nurses managers prefer that these nurses spend any spare time they have in providing general nursing care to hospitalized physically sick patients in general wards rather than pay consultative visits to rural health centres or visits patients' families.

3) There is still lack of trained psychiatric nurses to provide more skilled psychiatric care services at the third and fourth referral levels. These would also provide the necessary manpower for training their less qualified colleagues as well as providing regular outreach consultative and supportive visits to nurses in rural health centres and the community.

References:

Potloane E.L. "Lesotho Economic & Population Management" A paper presented at Lesotho National Conference on Population Management, 1979.

W.H.O.: "Mental Health" Afro Technical Report Series No. 7, Brazzaville, 1979.

THE USE OF SCREENING QUESTIONNAIRES BY FAMILY DOCTORS

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The General Health Questionnaire (GHQ) was designed to enable family doctors in London to screen patients in order to identify those with minor psychiatric illnesses. Such was my concern to capture the most telling phraseology for Londoners, that important items - such as those concerned with headache, tension and depressed mood - were tried in several different versions. In each case, the wording that produced the best discrimination between calibration groups was selected. This produced an instrument which worked well for Londoners,[1] and the author was pleasantly surprised to find that it worked fairly well in an American city after some of the items had been reworded to suit the local vernacular.[2] It had been designed to work well in a particular cultural setting yet it worked only slightly less well in a very different one.

Since then the GHQ has been translated into 16 languages and validated in 13 different countries: England;[1-14] Australia;[15-18] United States;[19-22] Mexico;[23-24] Austria;[25] Hong Kong;[26] Iceland;[27] India;[28] Jamaica;[29] Japan;[30] Yugoslavia;[31] Nigeria[30] and Spain.[32] The total score on the GHQ correlates highly with the total score on the Present State Examination,[7,11,16,18,21,22,30] or the Clinical Interview Schedule.[2,17,29,32] High correlations are also seen with other psychiatric screening questionnaires such as the Symptom Checklist,[19] WHO's Symptom Rating Questionnaire[26] and even scales specifically measuring depression such as the Hamilton Rating Scale for Depression[22] or WHO's Standardized Assessment of Depressive Disorders.[25] Although the GHQ does not make diagnoses high scores are likely in patients with depressive illnesses, anxiety states, minor mood disorders with somatic symptoms, acute schizophrenic illnesses and many alcoholics.

Table One shows nine validity studies that have been carried out in primary care settings. Understandably the highest validity coefficients were found with the London populations on whom the GHQ was calibrated, but they are only slightly lower in other English-speaking countries.

Table One: Validity of the GHQ in primary care settings

English-speaking	Design	sensitivity	specificity	correlation with criterion
London[1]	GHQ-60/CIS	91	94	.8
London[3]	GHQ-30/PSE	72	76	
Philadelphia[19]	GHQ-30/CIS	82	82	.7
Madison,Wisconsin[20]	GHQ-30/SADS-L	67	80	
Sydney[17]	GHQ-60/CIS	90	90	.76
Non-English-speaking				
Mexico[23]	GHQ-60/CIS	74	76	.62
Vienna[25]	GHQ-30/SADD	87	77	.61
Rejkjavik[27]	GHQ-30/PSE	76	79	.64

Table Two shows that the lowest validity coefficients are obtained with foreign language versions of the GHQ, although even with these, figures in the high seventies are usually obtained. It can also be seen from Table One that correlation coefficients between total GHQ score and criterion are usually obtained for foreign language versions of the questionnaire. Although the GHQ was especially designed for primary care settings, it appears to work equally well in hospital settings,[2,9,14,21,24] and is generally satisfactory in community settings.[4,7,8,10,12,13,16,18,31] The GHQ may miss some patients with long-standing disorders, so that in a random sample of menopausal women one study[8] showed a sensitivity as low as 54.5% for women whose illnesses had lasted an average 4.8 years; in contrast a random sample of unemployed adolescents[7] found a sensitivity of 100% for illnesses with a much shorter duration.

Table Two: Average validity coefficients found in the 32 validity studies cited, by setting in which the GHQ was administered and by language

	Sensitivity	Specificity
English-speaking	82.1	84.3
Non-English speaking	77.6	77.3
All primary care settings	80.7	82.0
All hospital settings	83.8	84.1
All community settings	80.1	87.1

WHY SHOULD IT WORK ACROSS DIAGNOSES AND ACROSS CULTURES?

The fact that the GHQ picks up a wide range of psychiatric disorders indicates that there is a common core of minor affective and psychophysiological symptoms in many different psychiatric syndromes. Because of the way in which it was constructed, the item content of the GHQ is focussed on the symptoms shared by a wide range of acute disorders: in arithmetical terms, items represent the "lowest common multiple" of psychological symptoms. The factor structure of these minor symptoms is remarkably constant in English respondents,[5] and the scales GHQ or GHQ-28 has been shown to be the best screening instrument to use in community surveys.[7] It is interesting to observe that factor invariance cannot be demonstrated across cultural barriers in that somewhat different structures can be shown for Mexicans[23] and American blacks.[19] It has been shown that respondents who are "fixed dependent" as measured by the Hidden Figures Test[33] have a less differentiated symptom structure with a larger proportion of total variances taken up by a general factor of psychological distress. In contrast, field dependent subjects make more differentiated responses to symptom inventories.

The fact that the GHQ is almost as effective in non-English speaking countries as it is in the populations for which it was originally designed indicates that there is a common language of psychological distress which cuts across cultural barriers. It would appear that attempts to make a psychiatric screening questionnairs culture-specific are only likely to add a few percentage points to the validity of coefficients achieved.

MANIPULATION OF THRESHOLD SCORE IN EACH SETTING

It is always necessary to find the optimum number of symptoms to distinguish between cases and normals in a given setting, and a small validity study should be carried out if optimal discrimination is to be achieved. Respondents asked to complete the GHQ as part of a research survey are likely to be more defensive than those completing it for their doctor as part of a medical consultation; while in settings containing many physically ill patients it may be necessary to raise the threshold considerably to obtain optimal discrimination.[14] This phenomenon can best be illustrated by six studies using the same version of the GHQ and using a criterion for caseness consisting of a highly structured research interview (the PSE) in which the decision concerning "caseness" is made by a computer.

LIMITATIONS OF THE GHQ

The author is familiar with work about 20 psychiatric screening questionnaires. All of them work, none of them make diagnoses reliably, and some undoubtedly work better than others. A screening test which gives the best results in one setting does not necessarily

give the best results in another. In round numbers, the GHQ is correct about four-fifths of the time. Researchers who only wish to avoid false positives can of course improve these figures by the simple expedient of raising the threshold score, just as someone who is mainly concerned about not missing cases can lower the score. Owing to the nature of the problem, the perfect screening test will never be found. In predominantly healthy populations (i.e., low prevalence) any screening test will have a low positive predictive value.[34]

There remain some limitations which are largely related to the form of the GHQ's response scale. The GHQ is likely to detect transient disorders which are likely to remit with minimal treatment, and to declare them cases. Indeed, most "false positives" are minor disorders of this sort. By the same token, it is likely to miss disorders of very long duration if respondents have come to accept their symptoms as "usual" for them. However, it is a simple matter to detect such cases either from their medical records or by adding a couple of extra questions.[25]

Table Three: Six validity studies of the GHQ-30 against PSE as a criterion

	Threshold Score
Icelandic general practice attenders[27]	2/3
US multiple sclerosis patients[21]	4/5
English unemployed adolescents[7]	5/6
Australian community sample[18]	5/6
London general practice attenders[3]	6/7
Australian unemployed youth[18]	6/7

REFERENCES

1. D. Goldberg and B. Blackwell, Psychiatric illness in general practice, B.M.J., 2: 439-443 (1970)
2. D. Goldberg, The detection of psychiatric illness by questionnaire, Maudsley Mono., No. 21, OUP
3. R. Finlay-Jones and E. Murphy, Severity of psychiatric disorder and the GHQ-30, Brit. J. Psychiat., 134: 606-616 (1979)
4. A. Tarnopolsky, D. Hand, E. MacLean, H. Roberts, R. Wiggins, Validity and uses of a screening questionnaire in the community. Brit. J. Psychiat., 134: 505-515 (1979)
5. D. Goldberg and V. Hillier, A scaled version of the GHQ, Psychol. Med., 9: 139-145 (1979)
6. P. Nott and S. Cutts, Validation of the GHQ-30 in post-partum women, Psychol. Med., 9: 139-145 (1979)
7. M. Banks, Validation of the GHQ in a young community, Psychol. Med., 3: 349-354 (1983)

8. S. Benjamin, P. Decalmer, D. Haran, Community screening for mental illness: A validity study of the GHQ, Brit. J. Psychiat., 150: 174-180
9. P. Maguire, D. Julier, K. E. Hawton, J. H. J. Bancroft, Psychiatric screening in general practice, Lancet, 1: 605-608 (1974)
10. A. H. Mann, The psychological effect of a screening programme and clinical trial for hypertension upon the participants, Psychol. Med., 7: 431-438 (1977)
11. J. Newson Smith and S. Hirsch, Psychiatric symptoms in self poisoning patients, Psychol. Med., 9: 493-500 (1979)
12. R. Jenkins, A. MacDonald, J. Murray, G. Strathdee, Minor psychiatric morbidity and threat of redundancy in a professional group, Psychol. Med., 12: 799-808 (1982)
13. R. Jenkins, Minor psychiatric morbidity in employed men and women and its contribution to sickness absence, Psychol. Med., 10: 751-758 (1980)
14. K. Bridges, Psychiatric illness on a neurological ward, M.Sc dissertation, University of Manchester (1983)
15. R. Finlay-Jones and B. Eckhardt, Psychiatric disorders among the young unemployed, Austr. N.Z. J. Psychiat., 15 265-270 (1981)
16. S. Henderson, P. Duncan-Jones, D. Byrne, R. Scott, S. Adcock, Psychiatric disorders in Canberra - A standardised study of prevalence, Acta Psych. Scand., 60: 355-374 (1979)
17. The GHQ - A valid index of psychological impairment in Australian populations, Med. J. Austr., 2: 392-394 (1977)
18. P. Duncan-Jones and S. Henderson, The use of a two stage design in a prevalence survey, Soc. Psychiat., 13: 231-237 (1978)
19. D. Goldberg, K. Rickels, R. Downing and P. Hesbacher, A comparison of two psychiatric screening tests, Brit. J. Psychiat., 129: 61-67 (1976)
20. E. Hoeper, G. Nyez, P. Cleary, D. Regier and I. Goldberg, Estimated prevalence of ROC mental disorder in primary medical care, Int. J. Ment. Health, 8: 6-15 (1979)
21. P. Rabins and B. Brook, Emotional disturbance in MS patients: validity of the GHQ, Psychol. Med., 11: 425- (1981)
22. R. Robinson and T. Price, Post-stroke depressive disorders: a follow-up study of 103 patients, Stroke, 13: 635-641 (1981)
23. M. Medina-Mora, G. Padilla, C. Campillo-Serrano, C. Mas, M. Ezban, J. Carevo, J. Corona, The factor structure of the GHQ - A scaled version for a general practice service in Mexico, Psychol. Med., 13: 355-362 (1983)
24. J. Vazquez-Barquero, J. Padierno Acero, C. Pena, A. Ochoteco, The psychiatric manifestations of coronary pathology: validity of the GHQ-60 as a screening instrument, Submitted to Social Psychiatry (1983)

25. H. Katschnig, W. Berner, H. Haushofer, M. Berfuss, P. Seelig, Psychiatric case identification in general practice: self-rating versus interview, Acta Psych. Scand. Supp. 285 62: 164-175 (1980)
26. D. Chan and T. Chan, Reliability, validity and structure of the GHQ in a Chinese context, Psychol. Med., 13: 363-372 (1983)
27. J. Stefannson and I. Kristjansson, A comparison of the GHQ and the CMI, Submitted to Acta. Psychiat. Scand. (1983)
28. V. N. Bagadia, et al, WHO project on effects of psychotropic drugs in different populations: WHO reports MNH/77.8 and MNH/78.6 (1975)
29. T. W. Harding, Validating a method of psychiatric case identification in Jamaica, WHO Bull. 54(2): 225-231 (1976)
30. National Institute of Mental Health, Ichikara, Japan. A translation of Goldberg's Maudsley Monograph into Japanese together with validation studies in Nigeria, India and Japan (1982)
31. Z. Radanovic and L. Eric, Validity of the GHQ in a Yugoslav student population, Psychol. Med., 13: 205-208 (1983)
32. P. Munoz, J. Vazquez, E. Pastrana, F. Rodriguez, C. Oueca, A study of the validity of Goldberg's GHQ in its Spanish version, Soc. Psychiat. 13: 99-104 (1978)
33. H. Witkin and D. Goodenough, Field Dependence and interpersonal behaviour, Psych. Bull., 84(4): 661-689 (1977)
34. K. Parkes, Field dependence and the factor structures of the GHQ in normal subjects, Brit. J. Psychiat., 133: 306-315 (1978)

IMPROVING MENTAL HEALTH PRACTICES IN PRIMARY HEALTH CARE

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BACKGROUND

Concern with understanding and improving the mental health role of primary care clinicians has been a research interest in the United Kingdom, the United States, and for the World Health Organization, for nearly 20 years. Michael Shepherd and colleagues (1966) led the way with research which combined an epidemiological approach to a patient population with examination of clinical practices. Subsequent research demonstrated a serious gap between the high prevalence of mental disorders among primary care patients and the concommitant low recognition, diagnosis, treatment or referral by primary care clinicians (Regier et al., 1978; Hooper et al., 1979).

Faced with a continued shortage of mental health professionals worldwide and a potentially important mental health role in primary care, the next step for primary care research is to test ways of improving mental health practices in primary care settings. The complexity of this problem can be seen by considering the sources of the problem and potential research approaches from four different perspectives: (1) physician characteristics, knowledge and behaviour; (2) patient behaviour; (3) the nature of the illness; and (4) service system characteristics.

1. Physician Characteristics, Knowledge and Behaviour

Possible constraints on a physician's mental health role have been identified. These include the physician's (a) interests and personality, (b) knowledge and skills, and (c) practice style. With regard to the first, Marks and colleagues (1979) found a

positive association between a conservative personality, low interest in psychiatric problems, and low recognition of mental disorder in patients. Personality is not a reasonable target for change, and recent evidence from a British survey of primary care physicians indicated that interest in providing mental health services has declined in the past decade (Cartwright and Anderson, 1981). However, in the Marks et al. study, recognition of mental disorder was positively associated with greater skill in clinical interviewing.

This second issue, adequacy of mental health knowledge and skills, has received considerable attention in the literature on training primary care physicians during their residency. A recent review of the US literature on mental health training for primary care physicians revealed a dramatic increase in efforts to teach interviewing skills and interventions for life crises, but failed to report any systematic approach to training in the diagnosis and treatment of mental disorders (Burns et al., 1983). More targetted approaches toward improving knowledge and skills have been directed toward the practicing primary care clinician. One major strategy for improving practice with increased knowledge of patient problems has been to use self-report symptom questionnaires in routine clinical practice. Recently, in research supported by the US National Institute of Mental Health at the Johns Hopkins University (1983), data suggest that General Health Questionnaire feedback to primary care physicians may have an impact on the physician's recognition of mental disorders among certain patient groups; the greatest effect is for patients 65 years of age and older, with a more moderate effect for men, non-whites and persons with less than a high school education. Also, the WHO Collaborating Study on Strategies for Extending Mental Health Care has shown that use of screening questionnaires, in combination with limited training for targetted mental health conditions, resulted in increased mental health care by physicians and ancillary personnel in developing countries (Harding et al., 1980; Climent et al., 1980). Further, Linn and Yager (1980) and Zung and colleagues (1983) have shown that screening questionnaire feedback about a specific type of disorder, namely depression, increased clinicians' sensitivity to the disorder.

A third aspects of physician behaviour affecting their mental health role is practise style (e.g., length of visit, tendency to order diagnostic tests and to refer to specialists). The amount of time spent with patients is particularly relevant to mental health care as it influences the extent to which verbal exchanges allow the physician to assess patient distress, life situation and functioning. In one comparison of four family physicians and 10

internists seeing over 1400 patients, we found that internists were more likely to identify mental disorder - the result of a longer initial visit to internists. First visits to family physicians tended to be of consistently shorter duration; therefore, initial recognition rates were low but caught up with those of the internists over the course of multiple visits (Kessler et al., unpublished). In addition to a general tendency for brief physician visits, which may not be unique to mental disorder, clinical practices relating specifically to mental disorder appear to differ from those for medical illness. The low rates of diagnosed mental disorder in visits to office-based physicians found in previous analysis prompted additional examination of the National Ambulatory Medical Care Survey (Regier et al., 1979). In searching for further signs of recognition of mental disorders, data were examined on reason for visit and provision of mental health treatment (psychotherapy/therapeutic listening and prescription of psychotropic drugs, excluding valium for muscle spasms). Altogher, 11.6% of visits could be seen as having a mental health component, in contrast to around 5% of visits in which a primary or secondary diagnosis of mental disorder was made. This much higher rate of recognition is accounted for largely by mental health treatment (psychotropic drugs, specifically) in visits where a mental disorder diagnosis was not recorded. In the case of medical illness, this practice of not documenting the reason for treatment is not consistent with prescribing drugs like penicillin, digoxin and cimetidine (Jencks, unpublished). One implication from this finding is that research must take into account such differences in the practice of primary care medicine as well as differences in attitudes toward mental health specialists.

2. Patient Behaviour

A second factor influencing a clinician's mental health role in primary care relates to patient behaviour. Although the clinical literature indicates that patients with mental health problems may present with somatic rather than psychological complaints, there has been little research evidence to this effect. In the Epidemiologic Catchment Area studies in the US we have had an opportunity to examine respondent-reported behaviour concerning their medical contacts. Among people in one of the areas studied (The Johns Hopkins University with an urban and heavily black population) with a diagnosed mental disorder and having visits to a general medical physician during the preceding six months, only 26% told their doctor that they had a mental health problem. Whether such limited communication is related to lack of patient awareness about their mental condition, fear of labeling, or limited mental health expectations of primary care physicians is

unknown. Although a causal link cannot be inferred, a clear association between telling a doctor about mental health concerns and seeing a mental health specialist was observed. It is impressive that among persons who reported mental health concerns to a nonpsychiatric physician, 25% saw a mental health specialist during the same six-month period, while among the 75% who did not relate mental health concerns to a primary care physician, less than 4% received any specialist mental health care (Kessler et al., unpublished). Such findings may have implications for educating patients to communicate mental health issues to primary care clinicians.

3. The nature of psychiatric illness

Another issue which has been reported to stand in the way of adequate attention to mental health problems by primary care providers is related to the conceptualization and classification of mental disorder in primary care (Regier et al., 1979). The traditional International Classification of Diseases (Section V) disorders are often neither comprehensible to primary care clinicians nor applicable to patients who present with a somatic component to their mental illness. The definition of a psychiatric case in general practice has been aptly reviewed by David Goldberg (1982) who identified three patient groups: (i) those with major psychiatric illness for whom physical treatments are valuable; (ii) psychological distress syndromes that are likely to remit without intervention; and (iii) psychological distress syndromes which require intervention. The problem with this classification, acknowledged by the author, is that research to differentiate between patients in groups (ii) and (iii) has not been done. There are some indications that psychological symptoms remit without treatment for significant groups of patients, but that symptoms persist when associated with certain diagnoses (Hankin and Locke, 1982; Barret and Hurst, 1982).

Steps towards identifying those problems, syndromes or disorders that are responsive to treatment in primary care may involve further study of traditionally defined disorders, but of equal importance may be epidemiological and clinical research in primary care on relationships between somatic and psychological symptoms for the purpose of identifying previously unclassified syndromes or disorders. Research by Eastwood and Trevelyan (1972) and more recently by Hankin et al. (1980) and Kessler et al. (1983) have demonstrated strong associations between the co-occurrence of medical and psychiatric conditions in addition to an extensive psychosomatic literature which examines such relationships. Toward this end, the World Health Orgnanization, in conjunction

with the National Institute of Mental Health and the Rockefeller Foundation, have proposed a triaxial classification for primary health care which calls for recording problems on physical, psychological and social axes (Lipkin and Kupka, 1982).

4. Service system characteristics

Finally, organizational factors influence the mental health role of primary care clinicians. The separate organization of health and mental health services has created physical and psychological barriers that limit accessibility and result in low referral rates even when mentalhealth specialist resources are available (Goldman et al., 1980). This fragmented approach makes it very difficult for health and mental health clinicians to coordinate care. In contrast, when health and mental health services are brought together through integrated organizations, attachment schemes or linkage models (Borus et al., 1980; Burns et al., 1980; Coleman and Patrick, 1976; Cooper et al., 1974; Corney, 1980; Harding et al., 1980; Regier et al., 1982), two kinds of findings have been observed. Primary care practitioners are more likely to identify mental disorder in their parents and to use mental health specialists for consultation and referral.

The cost of care and the potential for reimbursement also influence primary care practices. Experimentation with approaches to reimburse primary care practitioners for mental health services has not been aggressive. The complaint from fee-for-service physicians from spending the necessary time for psychosocial evaluation and treatment. One notable exception occurred in Canadian health insurance which reimburses physicians for providing psychotherapy at a competitive rate; following the introduction of such reimbursement, a dramatic rise in the amount of psychotherapy provided by general practitioners was observed (Richman et al., 1980).

CONCLUSIONS AND RECOMMENDATIONS FOR RESEARCH

Four factors that restrict the provision of mental health services in primary health care have been reviewed: the characteristics of primary care clinicians, of patients, of psychiatric illness in primary care, and of the health system. A major dilemma in thinking about how to improve mental health care has been to identify where the greatest impact might be. For example, would training clinicians, educating patients, improving the classification of mental disorders or ensuring adequate reimbursement for psychotherapeutic services in primary care offer the most critical place to start? Fortunately, there is sufficient interest in the problem that some work is underway in all areas.

Research focused on health provider behaviour represents the most extensive agenda. Descriptive studies are needed to understand the clinical process that primary care practitioners pursue when confronted with psychological or emotional problems in their patients. The rich literature on clinical decision-making offers some clues to research directions to identify points where some intervention may improve current practice (Eisenberg, 1979). Research on physician training represents another high priority, assuming that it is possible to design training programmes that are oriented to the diagnosis and treatment of specific disorders and placed in the context of patient history, functioning, coping ability, social supports and physical health. In addition, following further validation of screening tools and development of additional research measures (e.g., functioning), it should be possible to design outcome studies to assess specific primary care interventions for frequently occurring disorders, such as anxiety and depression. This will require testing clinical protocols and high-risk populations, such as the elderly, whose emotional problems and mental disorders are most often neither recognized nor treated (Butler et al., 1982), may be a sensible starting place.

The second area, patient behaviour, is underdeveloped, perhaps appropriately so. Educating patients to request help for problems that health professionals are not prepared to manage only creates frustration for both groups. Nevertheless, as mental health skills improve, clear patient/physician communication is essential for detection of emotional problems.

Third, research to clarify the nature of psychiatric illness in primary care will need to examine the course of disorders presented and related to clinical practices. Such research will contribute to determining conditions for which intervention is appropriate.

Fourth, examination of the relationships between the structure and organization of health care systems and mental health practices is very much needed. Country and cross-country comparisons of different models for organizing health and mental health services could potentially address issues such as the impact on patient outcome of separately organized versus integrated or linked health and mental health services. Within the health care system, the mental health role of nonpsychiatric clinicians needs to be differentiated from that of mental health specialists, as well as the specific roles of different mental health disciplines within primary care settings (Burns et al., 1979).

In conclusion, the preceding recommendations for research on mental disorder in primary health care constitute a long-term agenda. Varying perspectives from different types of health care systems and different types of health and mental health clinicians will be needed to cross-fertilize and enrich the thinking and research which needs to be done.

References

Barrett, J.E., Hurst, M.W. Short-term Symptom Change in Outpatient Psychiatric Disorders. Arch. Gen. Psychiatry Vol. 39, July 1982

Borus, J.F., Burns, B.J., Jacobson, A.M. et al. Coordinated Mental Health Care in Neighborhood Health Centers. Series DN No. 3 DHHS Publication No. (ADM)80-996, Supt. of Docs., Govt. Print. Office, Washington, D.C., 1980.

Burns B.J. Regier, D.A., Goldberg, I.D., Kessler, L.G. Future Directions in Primary Care/Mental Health Research. Int. J. of Ment. Health 8(2): 1380-1400, 1979.

Burns, B.J., Regier, D.A. A neighborhood Health Center Model of Integrated and Linked Health and Mental Health Services. In: Parron, D.L., Solomon, F. (eds) Mental Health Services in Primary Care Settings: Report of a Conference. Series DN No. 2, DHHS Pub. No. (ADM)80-995, Supt. of Docs., Govt. Print. Office, Washington, D.C., 1980.

Burns, B.J., Scott, J.E., Burke, J.D. et al. Mental Health Training of Primary Care Residents: A Review of Recent Literature (1974-1981). Gen. Hos. Psychiatry 5: 157-169, 1983.

Butler, R.N., Lewis, M.I. Aging and Mental Health. St Louis, Mo.: C.V. Mosby Co., 1982.

Cartwright, A., Anderson, R. General Practice Revisited. London: Tavistock Publications, 1981

Climent, C.E., Diop, B.S.M., Harding, T.W. et al. Mental Health in Primary Health Care. WHO Chronicle, 34:231-236, 1980

Coleman, J.V., Patrick, D.L. Integrating Mental Health Services into Primary Medical Care. Medical Care Vol. XIV, No. 8, 1976

Cooper, B., Harwin, B.G., Depla, C. et al. An Experiment in Community Mental Health Care. The Lancet, Dec. 7, 1974, p. 1356.

Corney, R.H. Factors Affecting the Operation and Success of Social Work Attachment Schemes to General Practice. J.Royal Coll. Gen. Practitioners, 30: 149-158, 1980

Eastwood, M.R., Trevelyan, M.H. Relationship between Physical and Psychiatric Disorder. Psychol. Med. 2: 363-372, 1972.

Eisenberg, J.M. Sociologic Influences on Decision-Making by Clinicians. Ann. of Internal Med. 90(6): 957-964, 1979.

Goldberg, D. The Concept of a Psychiatric "Case" in General Practice. Soc. Psychiatry 17: 61-65, 1982.

Goldman, H.H., Burns, B.J., Burke, J.D. Integrating Primary Health Care and Mental Health Services: A preliminary Report. Public Health Reports 95(6): 535-539, 1980.

Hankin, J.R., Shapiro, S. The Demand for Medical Service by Persons Under Psychiatric Care. In: Robins, L., Clayton, P., Wing, J. (Eds.) Social Consequences of Psychiatric Illness. New York: Brunner/Mazel, Inc., 1980.

Hankin, J.R., Locke, B.Z., The Persistence of Depressive Symptomatology among Prepaid Group Practice Enrollees: An Exploratory Study. Am. J. of Pub. Health 72(9): 1000-1007, 1982

Harding, T.W., De Arango, M.V., Baltazar, J. et al. Mental Disorders in Primary Health Care: A Study of their Frequency and Diagnosis in Four Developing Countries. Psychological Medicine, 10: 231-242, 1980.

Hoeper, E.W., Nycz, G. R., Cleary, P.D., et al. Estimated Prevalence of RDC Mental Disorders in Primary Medical Care. Int. J. Ment. Health, 8: 6-15, 1979

Jencks, S. Recognition of Mental Distress and Diagnosis of Mental Disorder in Primary Care (unpublished)

Kessler, L., Hoeper, E. W., Burns, B.J. Management of Emotional Problems by Internists and Family Practitioners. Paper presented at the Annual Meeting of the American Public Health Association, Montreal, Canada, 1982.

Kessler, L.G., Tessler, R.C., Nycz, G.R. Co-occurrence of Psychiatric and Medical Morbidity in Primary Care. J. of Family Practice 16(2): 319-324, 1983.

Kessler, L., Burns, B.J. Cross-site Comparison of People with DIS Disorders Among General Health Users (unpublished).

Linn, L.S., Yager, J. The Effect of Screening, Sensitization, and Feedback on Notation of Depression. J. of Med. Education, Vol. 55:942-949, 1980.

Lipkin, M., Kupka, K. (Eds.) Psychological Factors Affecting Health. New York: Praeger Publishers, 1982.

Marks, J.N., Goldberg, D.P., Hillier, V.F. Determinants of the Ability of General Practitioners to Detect Psychiatric Illness. Psychological Medicine, 9:338-353, 1979.

Regier, D.A., Goldberg, I.D., Taube, C.A. The De Facto US Mental Health Services System. Arch. Gen. Psychiatry, 35: 685-693,1978.

Regier, D.A., Kessler, L.G., Burns, B.J. et al. The Need for a Psychosocial Classification System in Primary Care Settings. Int. J. Ment. Health, 8(2):16-29, 1979

Regier, D.A., Goldberg, I.D., Burns, B.J. et al. Specialist/Generalist Division of Responsibility for Patients with Mental Disorders. Arch. Gen. Psychiatry, 39:219-224, 1982.

Richman, A., Brown, M.G., Hicks, V. Reimbursement by MEDICARE for Mental Health Services by General Practitioners - Clinical, Epidemiological and Cost Containment Implications of the Canadian Experience. In: Parron, D.L., Solomon, F. (Eds.) Mental Health Services in Primary Care Settings: Report of a Conference. Series DN No. 2, DHHS Publ. No. (ADM)80-995, Govt. Printing Office, Washington, D.C., 1980.

Shapiro, S. Secondary Prevention with Adult Patients in Primary Care Settings. Final Report. National Institute of Mental Health Contract No. 278-81-0025(DB), 1983.

Shepherd, M., Cooper, B., Brown, A.C., Kalton, G. Psychiatric Illness in General Practice. London: Oxford University Press, 1966

Zung, W.W. Magill, M., Moore, J.T. et al. Recognition and Treatment of Depression in a Family Medicine Practice. J. Clin. Psychiatry 44:1, 1983.

THE ROLE OF SOCIAL WORKERS IN PRIMARY HEALTH CARE DELIVERY

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Present Status of GP-Social Worker Collaboration

Despite the substantial literature testifying to the intermeshed nature of much physical and psychiatric ill-health on the one hand and social problems on the other, the response in terms of the appropriate services is far from co-ordinated. In Britain general practitioners are independent contractors to the National Health Service, the social services are administered by the local authorities. The Seebohm Report (1968), which was crucially influential regarding the decision that each local authority should establish a social services department, did emphasise the need for liaison between the general medical and social services.

"We regard teamwork between general practitioners and social workers as vital" the Report declared. "It is one of the main objectives and the likelihood of promoting it is a test we would like to see applied to our proposals for a social service department". Yet a decade and more later the relationship is far from that envisaged by Seebohm to judge by the comments of social workers responding to researchers investigating the social work task (Parsloe & Stevenson, 1978). The general practitioner was seen as someone with little knowledge of what social workers did, was critical of the professional standing of social work and treated social workers in a patronising fashion. While caution must be exercised in interpreting what is little more than anecdote and opinion, it is interesting to note that those social workers who were more favourably inclined towards GPs were working within some form of attachment arrangement in the primary care setting. As is clear from the literature in social work attachment schemes, collaboration between social workers and general practitioners is not without its hazards. Such schemes as are currently functioning well represent,

in numerical terms, but a tiny proportion of the social workers and the general practitioners working in Britain at the present (Harwin et al., 1970; Corney, 1980). Some observers like Dingwall (1979), disappointed at the lack of progress, conclude that short of a Royal Commission and a political initiative closer and statutory collaboration between health and social service personnel is inconceivable.

Prospects for Collaboration

Officially, the two organisations which represent general practice and social work in Britain endorse collaboration. Representatives of the British Association of Social Workers and the Royal College of General Practitioners have proposed that courses for the two professions should include opportunities for joint training and syllabuses should be altered so as to encourage the teaching of each other's roles and skills (BASW/RCGP, 1978). In Holland, such a course has been implemented with trainee GPs and social workers, the emphasis being placed upon the sharing of information and the acquisition of practical skills through role-play (Schenk, 1979). Unfortunately, there is no evidence that the participants' original prejudices were in any way altered. However, such courses can change attitudes according to one British GP trainer and his social work colleague on the basis of work undertaken with 17 trainee GPs and 18 community and hospital based social workers (Samuel & Dodge, 1981).

The remarkable organisational and educational developments which have been underway in British primary care for the past 15 years also bode well for improved social worker-general practitioner collaboration (Clare & Corney, 1982). The growth of the multidisciplinary health centre is one such development. In the five years between 1972 and 1977, the number of health centres in England and Wales rose from 212 to 731 and the Royal Commission on the Health Service estimated that there would be 900 by the end of the 1970s and 1000 by the early 1980s.

In addition, there are developments in the vocational training of general practitioners (R.C.G.P., 1979), a growing realisation concerning the need for a more appropriate range of therapeutic responses to the demands of psychosocial disorders (Clare & Lader, 1982) and a greater awareness of the shortcomings in the quality and competence of the primary care services at the present time (Cartwright & Anderson, 1981) which, taken together, all underline the need and the opportunity for professionals with social knowledge and skills to be deployed within primary care.

Effectiveness of Collaboration

Given that so much of the psychiatric morbidity detected in primary care has to be conceived in medical social rather than purely medical terms it is logical to attempt to introduce a diagnostic therapeutic element aimed at the social dimension of sickness by social workers themselves. Over a decade spanning 1973-1983 the General Practice Research Unit at the Institute of Psychiatry London included a team of four research social workers placed in a

local borough and four mornings a week one of the social workers was present at a local health centre for the morning surgery. Of the referrals which were made during these morning sessions most came mainly from the doctors with a minority being referred by health visitors and occasionally by the receptionists. The value of this attachment scheme has been attested by doctors, social workers and patients alike (two broad client groups appear to call pre-eminently for social work services: the young middle-aged married woman with family problems and the elderly). The therapeutic role of the attached social worker has been assessed in two separate studies. In the first of these a single social worker was given the task of treating a group of patients suffering from long-standing neurotic disorders, a comparison group being provided from another practice without such facilities (Cooper et al. 1975). Psychiatric and social status of the experimental group of patients before treatment and after 1 year was compared with the status of the control group and the resuls indicated that the experimental service conferred significant benefit on the patient population.

The results were sufficiently encouraging to justify the setting up of a controlled clinical trial of 80 patients with depressive disorders of recent onset. This is the first such study to be included in the field of social work. A total of 80 women were included in this study (Corney, 1981). The participating doctors were asked to refer women aged 18 to 45 years presenting with "acute" or "acute on chronic" depression. The duration of symptoms of depression in the former group was operationally defined as 3 months or less; in the latter group the symptoms may have been present for a longer period but had intensified in the preceding 3 months. A standardised clinical interview was administered to all these patients by psychiatrists and a social interview by a research worker. All women diagnosed as depressed by the psychiatrist were matched by age, marital status and chronicity of illness. They were then randomly assigned to the experimental group, i.e. to the care of one of the 4 social workers attached to the practice, or to a control group, receiving routine care by the family practitioner. After a period of 6 months they were reassessed by means of the same psychiatric and social instruments. Details of social work activity, medication and of the patients contacts with their doctors and other agencies were also recorded.

Significantly more patients with "acute on chronic" depression were found to improve when they received the additional help from a social worker. Whereas for "acutely" ill women this help had no effect.

The completion of this study demonstrates that it is feasible to carry out a clinical trial on social work intervention in primary care. It also indicates the great need to investigate further into the types of patients and problems that benefit from social work help in this context. Only through such studies can the most effective use of social work resources be made.

Problems of Collaboration

A major objection advanced against the argument for greater col-

laboration concerns time. The addition of a social worker can seem to the GP to be yet another member of a team who will demand as much time for consultation as he or she is likely to save in taking a share of the load. For the social worker, primary care is an area of work to be added to the long list of demands, including child care, the elderly, single-parent families, the handicapped and the mentally ill, being placed at social work's door.

There are also often major difficulties in the relationships between doctors and social workers, in part a consequence of the differences in status between the members of these professional groups. In addition, in Britain the general practitioner is an independent contractor with a varying commitment to anything resembling a team. Another problem is that social workers have a very different training and are no more familiar with the language and preoccupations of medical practice than any educated lay-person, and, in the main, adopt a sceptical view of the average doctor's interest in and awareness of social factors in relation to illness (Huntingdon, 1981). General practitioners, in the main, concentrate on the health or sickness of individual patients (Cartwright & Anderson, 1981) although a greater emphasis in training suggests that the new generation of practitioners may be more aware of the wider family and community aspects of their work.

Another serious objection advanced by some general practitioners, and the subject of much recent discussion in the light of the Barclay Report on the nature of social work (Barclay, 1982) is that it is not at all clear quite what it is that social workers do. There are those who argue that the most appropriate skill that a social worker should possess is an ability to know a considerable amount about social rights and services and be able to guide the client and the other members of the primary care team through the labyrinthine and ever-changing maze of social welfare legislation (Wootton, 1975). Indeed, Wootton is taken by the idea of being able to go directly to a social work professional "who being trained to function as a talking encyclopaedia, could deal forthwith with all the practical issues involved". However, while to some this may seem an eminently sensible use of social workers' skills and an appropriate way of ensuring the mobilization and co-ordination of the health and social welfare services in the interests of the individual within the community, not everyone takes such a view. Indeed, one critic has seen in the Scottish Social Work Act of 1968, with its emphasis on the social worker's remit to "promote social welfare", an opportunity merely for social workers to be developed into "a class of general dogsbodies" (Gammack, 1982).

Whatever the ultimate pattern of collaboration of social workers and GPs in primary care, there is a pressing need for a better, more detailed description of what it is that social workers do in this setting. There is a pressing need too to discover what general practitioners and other primary health care team members define as those social problems appropriate for referral to a social worker. What is it that distinguishes those clients so referred from the many more general practice patients who are never referred for social

work assessment and intervention ? What evidence, if any, is there for the suggestion that social workers in an attachment are involved at an earlier stage in the life history of social problems ? What are the "suitable client groups" which the DHSS Working Party on Research in Social Work identified as the appropriate target for social work experimental studies ? (DHSS Liaison Group, 1980). A number of patient groups come to mind including those experiencing marital problems, depression, recent family disharmony and disruption, and serious acute and chronic ill-health.

Conclusion

It is important that the difficulties involved for greater social worker-general practitioner collaboration are recognised, difficulties which include the high workload, the problems of measuring efficacy and outcome in such a complex and ill-defined area, and the differing ideological views concerning the nature of social work, and the inter-professional rivalries and anxieties which threaten to abort research before it can begin to bloom. But a greater involvement of social work in medicine and in particular in primary care would do much to restore the social dimension to the theory and practice of medicine and this is a powerful argument for continuing to deploy social workers alongside their colleagues in primary care medicine nursing and health visiting.

REFERENCES

BARCLAY REPORT. (1982).
Social Workers: Their Role and Tasks. National Institute for Social Work. Bedford Square Press: London.

BASW/RCGP. (1978).
Some suggestions for teaching about co-operation between social work and general practice. J. of the Roy. Coll. of Gen. Pract., 28, 96, 670-673.

CARTWRIGHT, A. & ANDERSON, R. (1981).
General Practice Revisited. Tavistock: London.

CLARE, A.W. & CORNEY, R.H. (1982).
Social Work and Primary Health Care. Academic Press: London.

CLARE, A.W. & LADER, M. (1982).
Psychiatry and General Practice. Edited proceedings of Mental Health Foundation Conference, Oxford, 1982. Academic Press: London.

COOPER, B., HARWIN, B.G., DEPLA, C. & SHEPHERD, M. (1975).
Mental health care in the community: An evaluative study. Psychol. Med., 5, 5, 372-380.

CORNEY, R.H. (1980).
Factors affecting the operation and success of social work attachment schemes to general practice.
J. of the Roy. Coll. of Gen. Pract., 30, 149-158.

CORNEY, R.H. (1981).
The Effectiveness of Social Work in the Management of Depressed Women Patients in General Practice. Unpublished Ph.D. Thesis (1981), University of London.

DINGWALL, R. (1979).
Problems of teamwork in primary care. Taken from: Teamwork In The Health and Social Services, (Eds. T. Briggs, A. Webb and F. Lonsdale), pp.111-137. Croom Helm: London.

GAMMACK, G. (1982).
Social work as uncommon sense. Br. J. of Soc. Wk., 12, 1, 3-22.

HARWIN, B.G., COOPER, B., EASTWOOD, M.R. & GOLDBERG, D.P. (1970).
Prospects for social work in general practice. Lancet, ii, 559-561.

HUNTINGDON, J. (1981).
Social Work and General Medical Practice. George Allen & Unwin: London.

PARSLOE, P. & STEVENSON, O. (1978).
Social Service Teams: The Practitioner's View. HMSO: London.

ROYAL COLLEGE OF GENERAL PRACTITIONERS. (1979).
Trends in General Practice. R.C.G.P., London.

SAMUEL, O.W. & DODGE, D. (1981).
A course in collaboration for social workers and general practitioners. J. of the Roy. Coll. of Gen. Pract., 31, 172-175.

SCHENK, F. (1979).
A course on collaboration between social workers and general practitioners during their vocational training.
Med. Educ., 13, 31-33.

WOOTTON, B. (1975).
A philosophy for the social services. Social. Comment., January, pp.ii-iii.

BARRIERS AGAINST THE IMPLEMENTATION OF MENTAL HEALTH CARE IN PRIMARY SETTINGS

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INTRODUCTION

Until now, this series of papers has focused on numerous strategies for successfully initiating mental health care in primary settings. These have included specific programs developed for the primary purpose of making mental health care accessible to populations which otherwise would not receive these services, or increasing the capability of those who work in primary settings to deliver mental health services to individuals who choose not to go to available mental health care settings.

Each of the strategies described has been successful on a limited basis, either within the specific countries and settings in which they have taken place or within the limited framework for which they were designed. At the same time, these specific options for introducing mental health care services into primary care settings raise several issues which suggest that barriers that are present will have to be overcome if mental health care is to be successfully introduced on a larger scale into primary settings.

The purpose of this concluding paper is to describe briefly the nature of some of the more significant barriers and to suggest some directions to be taken to overcome them.

THE ROLE OF THE PRIMARY CARE PHYSICIAN

The strategies described in these papers indicate that specialized training beyond that previously, and even currently, provided in medical school is required for primary physicians who are expected to deliver significant mental health services. Current curricula are inadequate in terms of the amount of knowledge which they provide regarding the care of those with mental disorders. Further, much of the current treating focus is on the most seriously mentally ill individuals; clinical training of medical students takes place most often on hospital units with most seriously disturbed patients. This creates a marked contrast with the types of patients most often seen in primary care settings, who are generally among the less severely mentally ill.

Attitudinal barriers are also present. Many primary care physicians, because of the imbalanced exposure to seriously disturbed patients during medical school, are hesitant and even reluctant to provide care to those with mental disorders who appear in primary care settings, even though they may be less seriously disturbed than the kinds of patients seen during their training.

Time constraints pose another significant problem. Since the majority of the patients seen in primary settings are less severely ill, they often are more amenable to cognitive rather than pharmacological interventions. However, these cognitive approaches require the greatest amount of time from the primary care physician, time which that physician may not be able or willing to give because of attitudinal constraints derived from earlier training experiences as mentioned above.

Several strategies are possible for overcoming this barrier. However, the path to achieving their implementation is extremely complicated and any simplistic statement of what they may be should not underestimate that complexity. Specifically, an increased knowledge base derived from revised medical school curricula will have to be achieved, focusing primarily on the dynamics and treatment of less seriously disturbed, nonpsychotic individuals. In conjunction with this, clinical experiences during medical training probably need to be redirected so that primary care physicians receive increased exposure to less seriously disturbed patients. Finally, despite a reported "oversupply" of physicians in some industrialized nations, it is clear that if primary care physicians and other workers are to play a greater role in providing care to the mentally disturbed in primary settings an increased availability of those personnel will be necessary so that the time required for cognitive care for those less disturbed individuals can be available.

THE ROLE OF THE PSYCHIATRIST

Traditionally, most psychiatrists have also been trained to serve primarily as direct providers of care to the mentally ill, focusing principally on the provisions of psychotherapy and the prescription of psychotropic medication.

With the limited supply of psychiatrists, particularly in developing countries, the overwhelming majority of the mentally ill cannot be carred for directly either by available psychiatrists or other mental health professionals (which are also in limited supply in many developing countries).

Therefore, both within developing countries and more industrialized nations, psychiatrists must assume other roles which will facilitate the enhanced availability of their knowledge and skills in order to have an effective and efficient impact on the population to be served.

For example, in the United States, it is estimated that at any given time only approximately 20 per cent of those in need of mental health care are seen within the formal mental health care delivery system. The remaining 80 per cent are seen in other systems of care, most notably primary health care settings or settings entirely outside the scope of the health care delivery system.

If psychiatrists and other mental health professionals are to have a significant impact on this 80 per cent, particularly those seen outside the formal mental health delivery system (as is particularly true in developing countries where the extensive range of outpatient services do not exist), then the role of psychiatrists and mental health professionals will have to undergo significant change.

The most significant redirection required is a transition of the role of many psychiatrists and mental health professionals to that of consultant rather than direct service provider.

However, most training programs spend only a limited amount of time on the development of consultatively oriented skills and techniques rather than those skills associated with direct service. While, more recently in the United States, greater attention has been given to the training of "consultation-liaison" psychiatrists, their role generally has been confined to working in hospitals as consultants on medical and surgical wards.

If the role of psychiatrists and other mental health professionals as consultants is to be enhanced and the current barrier decreased, then additional attention is going to have to be given to the development of curricula that focus on retraining as consultants rather than direct service providers so as to expand the scope of their influence.

INTEREST IN COMMUNITY-BASED CARE

It is somewhat paradoxical that at the same time interest is being generated in the implementation of mental health care through primary settings, psychiatry is in itself undergoing a revolution. Its practitioners are attempting to align themselves more closely with the "rest" of medicine and emphasize those professional activities which benefit from the significant advances in recent applications of biological psychiatry.

While the potential impact of introducing mental health services in primary care settings is increased substantially by the expanded availability of the products of these biological advances, principally psychotropic medications, it is also true that as more psychiatrists become biologically oriented, fewer will be available to act as program consultants for mental health services in primary settings. Further, as a new cadre of biological psychiatrists emerges, using psychotropic medications that impact more effectively on the most severely disturbed individuals, they will be less oriented toward working in primary care settings rather than other locales where the most seriously disturbed patients are seen such as private psychiatric hospitals and psychiatric units in general hospitals.

Therefore, more than ever, a need for a well formed subspecialty curriculum in social and community psychiatry is evident. This can provide a proper balance and ensure a cadre of program specialists who will work with community-based groups.

THE EMERGENCE OF SELF-HELP ORGANIZATIONS

Throughout the world, both in developing and industrialized nations, increasing attention is being given to the potential benefits available for many individuals with less severe emotional disturbances through the wide variety of recently emerging self-help organizations. They provide a different type of primary setting than general medical or family practice clinics. Their importance for the implementation of mental health care in primary settings cannot be ignored. At the same time, their increasing availability has been "threatening" to many mental health professionals who often perceive the care being provided through these organizations as "unprofessional" and "inadequate." These attitudinal constraints can create a significant barrier to the implementation of mental care in primary settings.

Consequently, there needs to be a greater reapproachment between psychiatrists and other mental health professionals with those "volunteers" who work in self-help organizations. This could be based on an enhancement of the consultative role of psychiatrists and other mental health professionals mentioned earlier. However, this also requires that self-help organizations and their voluntary leadership become less "frightened" of associateing with professionals b because it might undermine the purity of the self-help approach.

RESOURCE CONSTRAINTS

Interestingly, just as the push has emerged for the increased availability of mental health care in primary setting, increased emphasis within the formal mental health system on the care of the most seriously mentally ill individuals has required the need for a greater resource allocation for this population.

This creates competition between different aspects of the formal mental health system which require resources for the care of the most severely disturbed as well as competition between them and primary care settings which also demand increased resources if they are to expand to meet the needs of the less seriously disturbed.

This resource competition, particularly in the areas of the world where economic constraints are severe, also serves as an additional barrier to the implementation of mental health care in primary care settings.

To address these problems, two strategies could be kept in mind. First, while it is true that increased resources are required to care for the most severely mentally ill, it is often the case that less costly alternatives are often discarded in favor of more costly ones. A notable example is the failure to use with sufficient frequency family care and residental settings instead of hospitals. Second, there is the need to pursue further strategies of using in primary settings less costly personnel (other than professionals) who have been trained to provide support and intervention to less-seriously disturbed patients.

SUMMARY

While one should be encouraged by recent developments which have led to an expansion of the availability of mental health care in primary settings, it must also be recognized that common significant barriers continue to exist in many countries which will impact upon the ability to expand beyond the current limited initiatives.

The most common generic barriers are in areas such as the role of the physician, the role of the psychiatrist, the emergence of biological approaches to mental health care, the expansion of self-help organizations, and the competition issues resulting from resource constraints. This paper has attempted to identify these issues and to describe their roots. Some approaches to overcoming these barriers have been suggested.

Cooperative efforts between mental health professionals in different countries are required if these barriers are to be overcome. Succeeding with the expansion of mental health care in

primary settings through only the limited strategic approaches in specific settings will be insufficient over the long term. However, future accomplishments are dependent upon overcoming the barriers elucidated.

CONTINUITY AND DISCONTINUITY IN TREATMENT

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It was intentional on my part not to choose "continuity or discontinuity" for my title, for I hope to demonstrate that it is not a question of an alternative but rather of two possibilities of providing adequate care for psychiatric patients.

The problem we shall deal with is a relatively new one, since it was one which neither general medicine nor the psychiatry of our grandfathers had to think about. At that time, the general practitioner took charge of his patient from one end of life to the other, and one could speak of discontinuity only in the rare instances when the doctor had to send his patient to the hospital for a brief stay, notably for a surgical operation. Today, specialization in medicine as a whole and in psychiatry as well has brought new problems with it. Setting aside the question of continuity or discontinuity in general medicine and concentrating on the problem in psychiatry alone, we can see that it is not a type of specialization which calls for a great variety of diagnostic skills which has led to a situation of discontinuity, but rather the diversification of organisms and institutions. The problem first presented itself when there was not only the dichotomy of psychiatrist's office/psychiatric hospital but when outpatient services, mental hygiene clinics, homes for addicts, rehabilitation centers, day hospitals, etc., made their appearance. Then we found ourselves in the paradoxical situation that the better equipped a region was with psychiatric institutions, the greater was the danger that harmful effects would result from a multiplication of contacts between the psychiatric patient and a variety of medical teams. In theoretical terms, we can readily go along with such authors as Bachrach, who have analyzed the various dimensions of continuity of care. First, there is the dimension

of time. Treatment proceeds in parallel with the evolution of the patient's condition. It starts when the need arises and terminates only when the need has been satisfied; continuity must be assured, even if there are changes in those providing the care, in the place of treatment or even in the modalities of treatment. Respect for this longitudinal dimension avoids a situation in which different stages in the life of the patient, for example hospitalization and eventual rehabilitation, seem like isolated episodes, with no connection between them.

The second dimension is that of totality or of multidisciplinary care, in which social services, together with purely medical support, play a determining role.

The third dimension is that of flexibility. There is not necessarily a linear evolution, with constant forward progress. There may be comings and goings between the different services, with suitable care following the patient when he improves and also he decompensates.

The fourth dimension is at the level of relationships, for continuity of care also includes the relation between the patient and the person caring for him. We may note that this is not necessarily continuity in time with the doctor, for ties may also develop with other persons who are also regularly involved in care, such as nurses, social workers or handicraft teachers. This relational dispersion has the advantage of helping to avoid a very close interpersonal relationship when it is poorly tolerated by the patient. It makes possible the eventual development of what may be called an "institutional alliance". Such a relation doubtless exists more between the patient and the institution, in extreme cases with its very stones, than with any particular therapist. From this point of view, continuity of care must be understood not as a permanent doctor-patient relationship but rather more as permanence in a system of assuming overall responsibility for the patient. What matters is the quality of the care given, in which human warmth and kindness should theoretically prevail, regardless of any changes in personnel.

While care should be continuous, it must also be accessible. This accessibility may be considered at the purely material level, measurable in the number of kilometers from the patient's home to the place of treatment.

The advantages of continuity of care in a psychiatric institutional framework are quite clear : the patient, and above all the schizophrenic patient, must have definite points of reference, both in terms of the institution and of personal relations with one or another member of the therapeutic team. Over and over again, we have observed that a psychotic decompensation is triggered

simply by the fact that the doctor to whom the patient has become accustomed has to leave for another institution, thus breaking off the relationship.

However, even though continuity of care appears to be axiomatic, we have to ask ourselves whether it may not also present risks and have some negative aspects. In this connection, we might refer to Audisio, who fears that a systematic bias in favor of continuity of care may lead psychiatric hospitals to delegate their guardianship to extra-hospital institutions. He draws attention to the fact that some rest homes, lacking any therapeutic infrastructure, inevitably run the risk of reconstituting, perhaps in a worse form, the insane asylum world of yesterday, so justly denounced. We should be aware of the danger represented by the fact through the increasing close relations with the patient's milieu, psychiatry is setting up a kind of network, serving as a system of control over the mental patient, with the psychiatrist, in the long run, sharing his power with the family, the employer, the neighbors and the authorities, to arrive imsidiously at the psychiatrization of the community.

As Azoulay remarked, there is a contradiction which may remain latent and concealed or become apparent, between the continuity of the assumption of responsibility and the autonomization of the subject.

Apart from the fact that discontinuity in care may spare the patient from being caught up in an extremely tight network, we can sometimes observe in such discontinuity some positive therapeutic effects. For example, a patient who has been hospitalized on the occasion of an acute crisis may need to repress the painful experience of his decompensation, to put this part of the past behind him, and be able to go ahead with structuralizing work, together with people who did not know him in his time of "weakness". Whereas in analytic psychotherapy of neurotic patients such a tendency toward repression of elements of reality would very properly be the subject of analysis and introspection, in some cases of psychosis it may serve as a shield and a source of security. Accordingly, hospital psychiatrists should not be surprised to find that some patients turn their backs on them, forget all about them or even criticize them after recovery, since such behavior is part of a protective mechanism of self-healing.

Since the problem of continuity or discontinuity has a fallacious quality about it, we have chosen in our region to act pragmatically, from case to case. In other words, the doctor in charge of a case in the hospital service makes an assessment every time of the indications for continuity or discontinuity of treatment. To offer some examples :

A 24-year-old man with a personality of the borderline type underwent acute decompensations once or twice a year. Between hospitalizations he had great difficulty in fitting into society, maintaining stable relations with the people around him and integrating himself into his social and occupational surroundings. During his stays in the hospital, he was not always dealt with by the same doctor, the same nurse, social worker and occupational therapist -- but the institution itself represented to him a refuge, a grandmother perhaps, offering him security. After he left the hospital, he sometimes went back to his own neighborhood doctor, sometimes to a doctor in the outpatient service and sometimes came back to see the doctor who had cared for him at the hospital. In this case, we didn't consider it necessary to limit the patient's choice, and thus, tacitly, we favored discontinuity.

Another case was that of a girl with a neurotic depression who attempted suicide and was brought to the hospital. It was very soon found that she had a tendency to self sabotage, related to guilt toward her parents. An analytically oriented psychotherapeutic treatment was undertaken by the doctor who received her in the hospital division. After a short stay, she returned to her home and continued to be treated by the same doctor as an outpatient. At the end of a year, her condition was so much improved that she could be regarded as stabilized and in no further need of psychiatric care. In this case, continuity of care was an absolute necessity, due to the nature of her trouble, and due also to the psychotherapeutic relationship established at the very beginning between her and the psychiatrist.

The third case was that of a 30-year-old woman who came to the psychiatric outpatient service, where the doctor conluded that she was in the early stage of a schizophrenic evolution. She presented delirious ideas and an anguished sense of morcellation. She neglected her work and was engulfed in philosophico-mystic speculations. A good therapeutic relationship was nevertheless established between her and the doctor who received her. When an aggravation of her condition made hospitalization necessary, the same doctor continued to see her. After six months, the young doctor had to move to a post in another town. He told the patient in advance of his pending departure and carefully prepared with a colleague for continuity of care. However, the young patient could not support the change, which for her was a repetition of relational failures she had previously sustained. Ten days after the departure of the doctor, and despite the availability of the new therapist, she committed suicide by leaping from a bridge. In this case, discontinuity had catastrophic consequences.

Let us summarize :

As we said at the beginning, continuity and discontinuity are not alternatives but instead are two possibilities which must be assessed case by case. In considering the advantages and drawbacks of each, the doctor must bear in mind the patient's feeling of attachment to the therapeutic setting, the dimension of time, as expressed by Bachrach, the symptomatology, that is, the type of psychic disorder and its prognosis, and the family situation. An absolute and rigid rule should not be made. If, from case to case, there is a real choice between continuity and discontinuity, this will not constitute a restriction of our therapeutic options, but rather an enrichment.

REFERENCES

Audisio, M., 1982, Le service public de psychiatrie face au problème de la réhabilitation sociale et professionnelle des malades mentaux, L'information psychiatrique 58/3: 383-394

Azoulay,J., Bordes,J., Jany, J.-C., Le Guillou,A., Orsini,F., Prévost,J., La continuité des soins dans un service psychiatrique public, Evol. Psychiat. 38/1:135-176

Bachrach,L., Continuity of care for chronic mental patients : a conceptual analysis, Am. J. of Psychiat. 138:1449

THE PLANNING AND MANAGEMENT OF COMPREHENSIVE COMMUNITY MENTAL HEALTH SERVICES

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INTRODUCTION

Hitherto, planning of mental health services has not been sufficiently based on solid public health principles, such as the estimation of needs and registration and coordination of already existing resources, prior to establishing services.

Psychiatric research has revealed a gap between the real needs of the population and the ability of the services to meet these needs. This gap is due partly to the present organizational structure and partly to the lack of resources.

Based on advice from W.H.O. and in order to secure more goal-oriented services and more effective use of scarce resources, the mental health services of the western world is now being reorganized according to the principles of comprehensive community services. The ultimate objectives of reducing mental distress in general, of developing services to meet needs of risk-groups hitherto neglected, of increasing coordination of mental health - with general public health and social services and improving the quality of training of the professional staff, require the development of more accurate mental health information systems with inbuilt evaluation procedures in the service apparatus.

A review is given of the new principles for planning, evaluation and reorganization of the mental health services as integrated parts of the general public health services.

EPIDEMIOLOGIC ASPECTS

The concept of community psychiatry has universal value and reflects trends of our time, patterned by an increasing public demand on participation in the democratic decision process based on more or less realistic expectations. This process is partly a function of the development of mass media, which also makes underprivileged groups increasingly aware of the unequal opportunities regarding skilled treatment. Community psychiatry therefore aims at improving the effectiveness of services in meeting perceived needs of the population at risk.

Actual studies have demonstrated the connection between sociodynamic factors and mental disorders. Supported by recent legislation, this has given a stimulus to the creation of comprehensive medico-social services with an extension of professional responsibility beyond the diagnosis and treatment of manifest disease into the field of public health and social and preventive medicine. This comprehensive approach has necessitated inquiry into the real needs of the population and has uncovered deficiencies in the resources and organization of health and social services.

Since the distribution of mental disorders in populations shows correlation with demographic features and with sociocultural conditions (such diseases being more prevalent among the old than the young, in people of lower rather than higher socioeconomic strata and in people in disorganized social environments rather than in well-integrated communities), this situation has implications for the organization of the service structure.

Effective extension of mental health services therefore calls for an epidemiological, sociological and socioeconomic screening of the catchment area with regard to:

1. Incidence and prevalence of mental disorder, including registration of groups at risk.
2. A socio-dynamic assessment of the community with respect to the occurrence and distribution of social stress and degree of integration.
   (Here, definite features in the structure of the community are brought out, which can be correlated with the distribution of mental illness in the population, thus revealing indicators for social change.)
3. A systematic registration of all manifest and potential supportive and therapeutic resources. The service apparatus must aim at a coordinated presentation of

health and social services, in which fragmentation is avoided and continuity secured.

This survey will ideally provide us with "an Individual Patient Profile", "a Community Profile" and a "Service Profile", which can be matched with each other.

SERVICE ELEMENTS

Principally, community mental health services should include the following five essential elements: inpatient services, outpatient services, partial hospitalization services, emergency services and consultation and education services to community agencies and professional staff. To these should be added diagnostic services, rehabilitative services (including vocational and educational programs), pre- and after-care services (including foster home placement and halfway-houses), training, research and evaluation. Generally, these components have now been accepted in most Western countries as the ideal basis for a truly comprehensive psychiatric service, though their realization to a full extent varies greatly from country to country.

The comprehensiveness of services implies a catchment area responsibility not only for diagnosis, treatment and rehabilitation, but equally for the prevention of disease. Combined responsibility for all age groups secures a family-centered approach, whereby both the patient and his primary group can be followed through their life and family cycle in an ecological frame of reference.

Extension of services into the patient's own neighbourhood is of central importance, as it allows treatment to take place in his natural environment where the symptoms have arisen, where they can most successfully be treated as a product of interpersonal and psychosocial conflicts, and where the patient must be helped to function again.

The various essential components of the community mental health center constitute a differentiated apparatus, representing flexible steps of a treatment continuum. The inclusion of rehabilitation services and of pre- and after-care, prevents the development of institutionalism or hospital artifacts and secures continuity of care. Emergency care is based on the experience of crisis-intervention, which can be a highly successful method of treatment, due to the patient's motivation being at an optimum in crisis. However, consultation and education service also deserve the utmost attention, constituting functions which

in many countries have not been given sufficient priority. Consultation implies psychiatry moving into the total public health field, which is concerned with the prevention of disease and promotion of health in the widest sense. We will never have enough mental health professionals to deal directly with all patients presenting psychiatric problems; nor would it be desirable from a professional point of view. We should rather utilize more of our resources in enabling community agencies and key personnel to deal successfully with psychiatric problems on a casefinding, early-diagnosis and early treatment basis before the clients end up as psychiatric "cases", thus also fostering preventive aspects. The importance of a program-centered and consultee-centered case consultation cannot be overemphasized, since this is one way in which mental health professionals get confronted with socio-dynamic factors causally involved in the development of psychiatric disorders. If these factors are not taken into consideration, mental health professionals end up merely as symptom-relievers.

The relevance of health education must also be underlined, since it prepares the ground of our programs in the community, through creating tolerance and insight into psychiatric problems.

However, eagerness in securing coordination of medico-social services paradoxically enough can threaten the quality of treatment to the individual patient and his primary group. Many community mental health centers are finding themselves in a turmoil, forced into an attitude which is mainly determined by administrative management of patients.

The successful implementation of community health projects must be dependent on a broad-based behavioral science approach, in order to understand the dynamics of the society for which we are planning services. For too long we have set up programs without paying sufficient attention to basic public health principles, epidemiological data, systematic evaluation, the occurrence and distribution of social stress and the catchment area's degree of socio-cultural integration. Programs which thus take account of the constant dynamic interaction between the individual and his social setting, uncover a need for inducing social change. In this way, the mental health apparatus functions as a catalyst. A bilateral identification between the community and the mental health service, especially when working with underprivileged groups, is of central importance. This identification must also be re-

flected in the composition of the staff. Correspondingly, any mental health programs which do not take these psychosocial forces into consideration are apt to fail, because we are not meeting the population on the basis of their basic felt needs.

EVALUATION

The assessment of medical care quality has traditionally focused on examination of individual physician performance. The medical profession itself in cooperation with the official authorities has ensured quality through controlling training programmes, licensure, speciality examinations, etc.

Since 1970, special standards for evaluation of psychiatric facilities have been adopted by the American Psychiatric Association and The Joint Commission on Accreditation of Hospitals.

With the United States Social Security Act of 1972, a Professional Standards Review Organization System (PSRO) was required built in with the Community mental health center-services, in order to obtain federal support.

In Norway, the Medical Association, in cooperation with the medical faculties, on "delegated authority" from the authorities, has exerted quality control through standard requirements, demanded of institutions as well as of candidates themselves.

The resource-crisis accentuated with increasing costs in the health service, has necessitated the development of formal, more comprehensive procedures for evaluating quality and effectiveness in relation to invested resources, where the authorities are directly involved through legal enactments. In order to secure an evaluation mechanism that is patientoriented with due emphasis on confidentiality, the health professions themselves must be involved.

FINAL REMARKS

The success and the very survival of community psychiatry is dependent on our going slowly and realistically forward, in close cooperation and concordance with the community. We must avoid giving rise to expectations greater than we can meet, thus securing quality of services both on a group- and on individualistic psycho-dynamic basis. This implies our defining clearly to society the

limitations of our professional competence as to what is pertinent to psychiatry and mental health.

The psychiatrist's identity as a medical professional, based on a biological-psychodynamic and psychosocial-educational background, gives him particular opportunities and responsibility as a coordinator. This brings with it special demands on psychiatric education which must be strengthened, not only with regard to social psychiatry but also psychodynamic theory and method and the whole field of behavioral sciences. The tendency toward omnipotence in the Community Mental Health Movement, with a resulting danger of blurring of roles, both within the multidisciplinary team itself and versus community leaders, may consequently lead psychiatry to drift away from medicine and public health. This will, from my point of view, represent a tragedy to both the individual patient and society.

Bibliography

World Health Organization, Regional Office for Europe, Copenhagen: Country Programme Profiles of Europe, 1982

THE FIRST COMMUNITY MENTAL HEALTH CENTER IN GREECE:

THREE YEARS ASSESSMENT OF AN EXPERIMENT

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INTRODUCTION

In Greece there is a wide consensus among state officials, professionals in health care field and the general public that the existing mental health care delivery system is inadequate and poorly organized.[1,2] The need for planning of decentralized and effectively coordinated community services has long been accepted but only sporadic attempts towards this direction were made.

In view of the situation in 1978, the Department of psychiatry of Athens National University, in Eginition Hospital took the initiative to establish the first Community Mental Health Center (CMHC) in the country as part of a network of University Mental Hospital Services.

The center serves an area of nearly 100.000 residents in the Athens greater Area and it started providing actual services and programs to the community in October 1979.

The purpose of this paper is to present a short-term evaluation of the CMHC activities during the first three years of it's operation (1979-1982).

THE DEVELOPMENTAL STAGE

The CMHC is serving the two neighbouring boroughs of Kessariani and Byron in about 1.5 km from the Eginition Hospital in which the department of Psychiatry is housed since 1905. The two boroughs were established after 1922 and they expand to an area of 8.4 km^2

with a population most comprising of working and middle class residents (fig. 1).

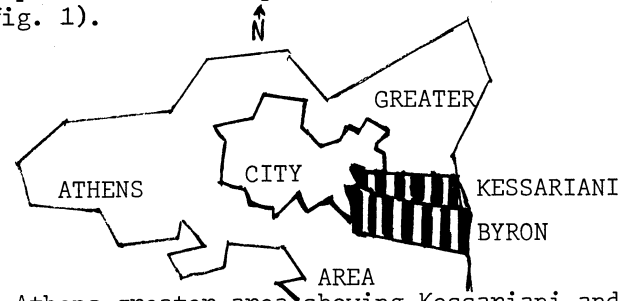

Fig. 1.: Athens greater area showing Kessariani and Byron boroughs

The center is part of the department of Psychiatry Mental Health Services

A detailed analysis of the CMHC activites and their integration with the University Mental Health Services was presented elsewhere.[3] The center is staffed by a multiprofessional team consisting of 13 members including psychiatrists, social workers a clinical psychologist, a visiting nurse, social scientists, clerical staff, and a number of unpaid volunteers residents of the community. Due to budgetary constraints graduate students in social work, occupational therapy and public health nursing were employed. Similar approaches are reported by others.[4] Prior to the actual operation of the center an assessment of community's mental health needs was make by conducting a cross sectional prevalence home survey with a two stage systematic sample of 1575 respondents representing 15% of the total households and by establishing an extensive community referral network (Fig. 2.). This phase lasted ten months.

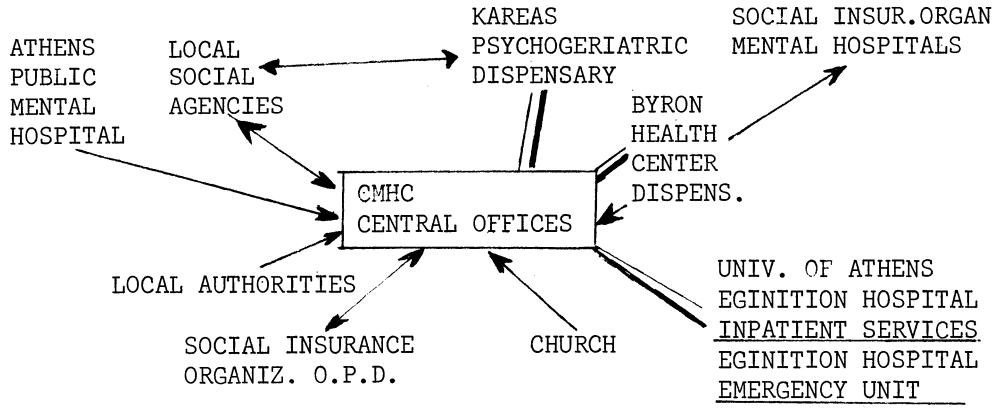

Fig.2.: The C.M.H.C. referral network

The CMHC is operating on the basis of community psychiatry principles i.e. comprehensiveness, continuity of care, prevention, research evaluation and consumers' participation.[5]

The delivery of mental health services includes:

1) the operation of a walk-in clinic five days a week. Clients are met by a member of the psychiatric team. Intake, of course, is restricted to local residents.
2) A follow up clinic once a week for chronic patients (a long acting drug clinic).
3) An outreach program for clients who although have visited the Emergency Service at the Eginition Hospital and have been referred to CMHC do not show up.
4) A home treatment and crisis intervention service.
5) The operation of a child guidance clinic.
6) Mental health consultation by the non psychiatric staff of the CMHC.

An evaluation and research unit is providing a feed back information by evaluating the effectiveness of services. The organizational structure of CMHC is shown in fig 3.

KESSARIANI-BYRON CMHC

SERVICES			PROGRAMS	
OPEN PSYCHOSOCIAL CARE	MENTAL HEALTH CONSULTATION	EVALUATION AND RESEARCH	PREVENTION NEIGHBOURHOOD MENTAL HEALTH COMMITTEE	EDUCATION TRAINING IN CMH THEORY AND PRACTICE OF MH PROFESSIONALS AND STUDENTS
Walk-in clinic Follow-up clinic Child guidance clinic Outreach program Home treatment and Crisis Intevention Psychogeriatric dispensary at Kareas Psychiatric Dispensary at Byron Health Center			MH INTERVENTION IN SHCOOLS LOCAL ORGANIZ.	

Fig. 3.: The CMHC organization structure

The pressure of growing demands and the specificity of mental health unmet needs of two specific areas of the community has soon prompted the opening of two small psychiatric dispensaries located the first in the Kareas House for the Elderly and the second in the Byron Health Center, operating by a visiting psychiatrist assisted by the local social services.

There are various forms of care provided by the CMHC including diagnostic, psychometric and psychotherapeutic intervention with the individual and the family in a type of supportive, or brief psychotherapy and drug maintenance, behavior therapy and in some occasions family therapy, family consultation, social case work,recreational activities and occupational therapy.

In some cases of chronic mentally ill, institutionalized in the community, a social support system was organized mainly by mobilizing community resources.

The center provides full services all mornings and twice a week in the evenings. Practically all clients can reach the center, in less than 10 minutes.

EVALUATION

A built-in evaluation system was established from the beginning for the purpose of obtaining the necessary knowledge about the clients' flow, their characteristics and the effectiveness of care. A total of 446 clients (154 males and 292 females) have visited during the first three years for the first time the CMHC adult services in central building, psychogeriatric dispensary and the Byron Health Center dispensary. A great number of clients residents of the Kessariani borough, mostly residing in the central slum area visited the CMHC adult services in the central building. Their average age was 38.0 (±17.8) years and 38.17 (±16.8) for males and females respectively.

Most of the clients (both sexes) were married. In their majority the single clients were diagnosed as suffering from schizophrenic psychoses.

The distribution of clients by their socioeconomic status (education X occupation) showed similar patterns with the local census sociodemographic characteristics.

A variety of community sources including neighbors, other clients, local agencies, authorities and the Eginition University Mental Hospital referred clients to CMHC services. Differences by referral source are shown in table 1.

Table 1. Distribution of clients by the source of referral by sex (first attendances in adult services 1979-1982).

Source of referral	MALES		FEMALES		TOTAL	
CMH research projects	30	19.5	42	14.4	72	16.1
Neighbors	23	14.9	25	8.6	48	10.8
CMHC clients	18	11.7	40	13.7	58	13.0
Sociomedical agencies	32	13.0	94	32.2	126	28.2
Eginition Hospital	20	20.8	31	10.6	51	11.4
Local Authorities	6	3.9	20	6.8	26	5.8
Private physicians	9	5.8	8	2.7	17	3.8
Self referred	10	6.5	17	5.8	27	6.1
Unknown	6	3.9	15	5.1	21	4.7
TOTAL	154	100.0	292	100.0	446	100.0

X^2:69.199 DF 8 P<.0001

Different primary causes of referrals were noticed for males and females and these differences were found to be statistically significant (P<.001). Most of the males reported physical/social problems while the majority of females presented emotional problems.

There is a 548% increase of the total attendances between 1979-1982 in adult and children services and a 235% increase in home visits. A number of 3.194 total attendances were recorded during the first three years of C.M.H.C. operation (table 2).

Table 2. Percent increase of total attendances of CMHC children and adult services and home treatment-outreach program between 1979-1982.

Total number of attendances	First year		Second year		Third year		Total	
Adult and children services	256	73.9	836	+226.5	1660	+49.6	2752	86.1
Home treatment and outreach program	90	26.1	51	- 56.6	301	+590.2	442	13.9
Total	346	100.0	887	+156.3	1961	+121.0	3194	100.0

The diagnostic distribution of male and female clients is shown in table 3. The majority of the clients of both sexes was diagnosed as suffering from neurotic and personality disorders but there are sex differences in some other diagnostic categories at a P<.0001 level. More males were diagnosed as schizophrenics and alcoholics than females.

Table 3. Distribution of clients by diagnosis and sex (first attendances in adult services 1979-1982).

DIAGNOSIS	(ICD9)	MALES		FEMALES		TOTAL	
Organic psychotic conditions	(290-4)	8	5.2	17	5.8	25	5.6
Schizophrenic psychoses	(295)	32	20.8	31	10.6	63	14.1
Affective psychoses	(296)	17	11.1	43	14.7	60	13.4
Neurotic and personality disorders	(300-301)	49	31.8	159	54.5	208	46.6
Alcohol depend/Syndrome	(303)	6	3.9	-	-	6	1.4
Drug dependence	(305)	3	1.9	2	0.7	5	1.1
Mental retardation	(317.19)	7	4.5	7	2.4	14	3.2
Other		32	20.8	33	11.3	65	14.6
TOTAL		154	100.0	292	100.0	446	100.0

X^2: 38.019 DF 7 P<.0001

More than the half of the clients of both sexes received supportive psychotherapy along with drug maintenance. A small number of clients were referred to other services (inpatient or childrens special services).

Table 4. Distribution of clients by type of care and sex (first attendances in adult services 1979-1982).

TYPE OF CARE	MALES		FEMALES		TOTAL	
Consultation-Social case work:	39	25.3	90	30.8	129	28.9
Supportive Psychother.+ Drug maintenance:	87	56.5	177	60.6	264	59.2
Social support system reorganization:	3	1.9	4	1.4	7	1.6
Other psychotherapies:	7	4.6	6	2.1	13	2.9
Referred to inpatient services:	2	1.3	2	0.7	4	0.9
Referred to other services:	16	10.4	13	4.4	29	6.5
TOTAL	154	100.0	292	100.0	446	100.0

X^2:218.137 DF 5 P<.0001

Finally, most of the clients continued to be in contact with the CMHC services at the time of the evaluation. A 20% of clients terminated their contact due to therapist's decision. A low mobility rate for both sexes was noted.

DISCUSSION

A preliminary evaluation of the operation of the Kessariani-Byron CMHC over the first 36 months of its developmental period shows that there is a striking similarity with CMHCs' in other countries in most of the investigated variables.[6,7] This finding is of importance considering not only differences in sociocultural millieu between centers but also the fact that the Kessariani-Byron CMHC operates on an experimental basis and is lacking a nation-wide legislative framework regulating referral network. The total number of 446 clients represents only a small percentage of the population potential users, according to the prevalence rates of psychopathology in the community.[8] The progressive increase in the number of clients every successive year however indicates that community oriented mental health care receives a growing acceptance.

As in similar services in other countries women tend to seek help

more frequently than men for emotional or psychosocial problems related to their family life requiring psychological intervention. The great number of clients who used the CMHC services for counsultation only most likely reflects the prevalence of socioenviromental problems in the community (poor housing, low family income, unemployment, one parent families) and provides an indication of how wide a spectrum of functions and services can be offered by a community based mental health care system.

Based on the experience aquired up to this date from the operation of CMHC it is the firm belief of all professionals working in the center that it will soon develop to an essential part of the comprehensive mental health care system, with the specific advantage over hospital-based services it's potential to fill the gap between help-seekers and providers and thus mobilize local resources to effectively meet community mental health needs.

REFERENCES

1. M. Madianos, Mental illness and mental health care in Greece, Publ. Hlth Rev. 11, 1:73 (1983).
2. C. Stefanis and M. Madianos, Mental health care delively system in Greece in Aspects of preventive of Psychiatry G. Christodoulou. Ed., Karger, Basel (1981).
3. C. Stefanis and M. Madianos, University mental hospital and community mental health center: Competing or complementary services in General hospital psychiatry, J.J. Lopez Ibor J.R.J. Saiz, J.M. Lopez Ibor Ed., Excerpta Medica, Amsterdam (1983).
4. V. Bohr, The use of students as employees in a community mental health center in the Community Mental Health Center, A. Beigel and A. Levinson Ed., Basic Books, New York (1972).
5. M. Madianos and C. Stefanis, Developmental issues and intervention strategies in a community mental health center in Greece paper presented at the 8th World Congress of Social Psychiatry Zagreb 1981.
6. E. Gruenberg, Evaluating the effectiveness of Community mental health services Milbank Mem. Fund, New York (1966).
7. M. Kramer and C.A. Taube, The role of a national statistics programme in the planning of community psychiatric services in the United States, in Roots of Evaluation J.K. Wing and H. Hafner Ed., Oxford Univ. Press London (1973).
8. M. Madianos, N. Vaidakis, V. Tomaras and A. Kapsali, Psychiatric Case identification in the community: coeficients of agreement between two pairs of observers, mimeographed (1982).

TO PLAN AND MANAGE COMPREHENSIVE COMMUNITY MENTAL HEALTH SERVICES

- USING CASE REGISTERS

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In many European countries the trends of the organization of mental health services of the years 1970 to the beginning of the 80's have been dominated by alterations to more comprehensive systems of different types of psychiatric treatment.

The pattern described by Brown (1960) with a steadily growing length of hospital stay during the period from 1880 to about 1950 already during the 60's changed into a decline of the length of stay in order to avoid the increasing number of beds and the overcrowding of mental hospitals.

There has been an increased tendency to use treatment in out-patient clinics, treatment by a growing number of private psychiatrists, special out-patient clinics for alcoholics, of psychiatric nursing homes, and services by psychiatric nurses and other types of community services.

As the Danish nationwide central psychiatric register was established already in 1970, it has been possible to follow the development of the following figures. Table 1 shows the total number of beds in absolute number and per 1,000 inhabitants. The number of beds includes all age groups and also a small number of facilities for day-patients. Throughout the 50's and 60's there was an increase until the year 1970, and since then there has been a decrease in the number of beds from about 11,600 to about 10,000 and the rate per 1,000 has decreased from 2.3 to 2.0 beds. At the beginning of the 70's the facilities for day and night-patients were about 10%, in 1977 about 15%, and is now 20% of the beds/facilities for in-patient treatment. The total number of admissions (in-patients) (including all ages and also including admissions as day-patients) has declined from about 43,000 to about 40,000, and the rate from 8.5 to about 8, as shown in Table 2. Table 3 shows the number of bed days for in-patients including day and night-

Table 1. Total number of beds in absolute number and per 1,000 inhabitants.

YEAR	BEDS	r/1,000
1977	11,597	2.3
1978	11,511	2.3
1979	11,244	2.2
1980	10,878	2.1
1981	10,471	2.0
1982	10,311	2.0

Table 2. Total number of admissions (inpatients) in Absolute number and per 1,000 inhabitants.

YEAR	ADMISSIONS INPATIENTS	r/1,000
1977	43,220	8.5
1978	43,854	8.6
1979	42,146	8.3
1980	42,065	8.2
1981	40,349	7.9
1982	40,364	7.9

Table 3. Total number of bed days (inpatients) and per 1,000 inhabitants.

YEAR	BED DAYS	r/1,000
1977	3,782,573	745
1978	3,704,993	727
1979	3,596,461	704
1980	3,456,991	675
1981	3,330,931	650
1982	3,242,294	633

patients of all ages with a small decline from about 3,700,000 to about 3,200,000, but the rate has decreased from 745 to 633 per 1,000 inhabitants. Figure 1 shows the same pattern. Since 1970 there has been a rather stable number of admissions. Figure 2 shows the number of first admissions per 10,000. (The increase of the curve in 1970/71 is artificial and caused by inclusion of clinics and hospitals for alcoholics).

Out-patient activities are not registered comulatively but counted and reported to the National Health Service of Denmark. There has been a great increase in the number of cunsultations in the out-patient hospital clinics, from about 20,000 at the end of the 60's to about 175,000 in the beginning of the 80's with an increase in the number of treated patients from about 5,000 to 35,000 in this period. This means that the number of treated patients has increased about 10 times and the number of consultations about 8 times. (Fig. 3).

I will not allow myself to go deeply into the many trends, but only point out that at the same time as the number of admissions of in-patients has shown a slight decline, there is an increasing number of admissions per bed, the ratio showing a slight increase (se Table 4), but at the same time the bed days per bed have decreased. One of the aims of the planners has been to increase utilization of the hospitals and they generally evaluate this by counting the number of bed days; the increase of admissions per bed is at the same time supposed to be an indicator of an intensification of the work. However, there is a decline of the bed days as shown in Table 4.

Cases with duration of more than 3 months has for many years been rather stable with only about 10% of all admissions. An analysis of the old long-stay and new long-stay patients (Weeke et al., 1977) shows that there is a tendency to a decrease in both categories. A group of patients are readmitted many times. A special study of this group of "revolving-door patients" is important (Kastrup at this congress).

DISCUSSION

The intentions of the planners have been to reduce the in-patient treatment by more intensified alternative services offered to the population. However, studies of Kastrup (1980) have shown that it is not possible.

Through cross sectional analyses (Weeke and Strömgren, 1978), cohort analyses, etc. it has been possible to show that establishment of out-patient clinics for alcoholics, intensified out-patient treatment in the psychiatric department of the regional hospital, intensified treatment by private psychiatrists, and other new possibilities of treatment have not reduced the need of in-patient treatment. The same results have been found during the years of the project of the island of Samsø: The need for hospitalization has not been reduced throughout a period of about 20 years of community psychiatric service (Nielsen et al., 1981).

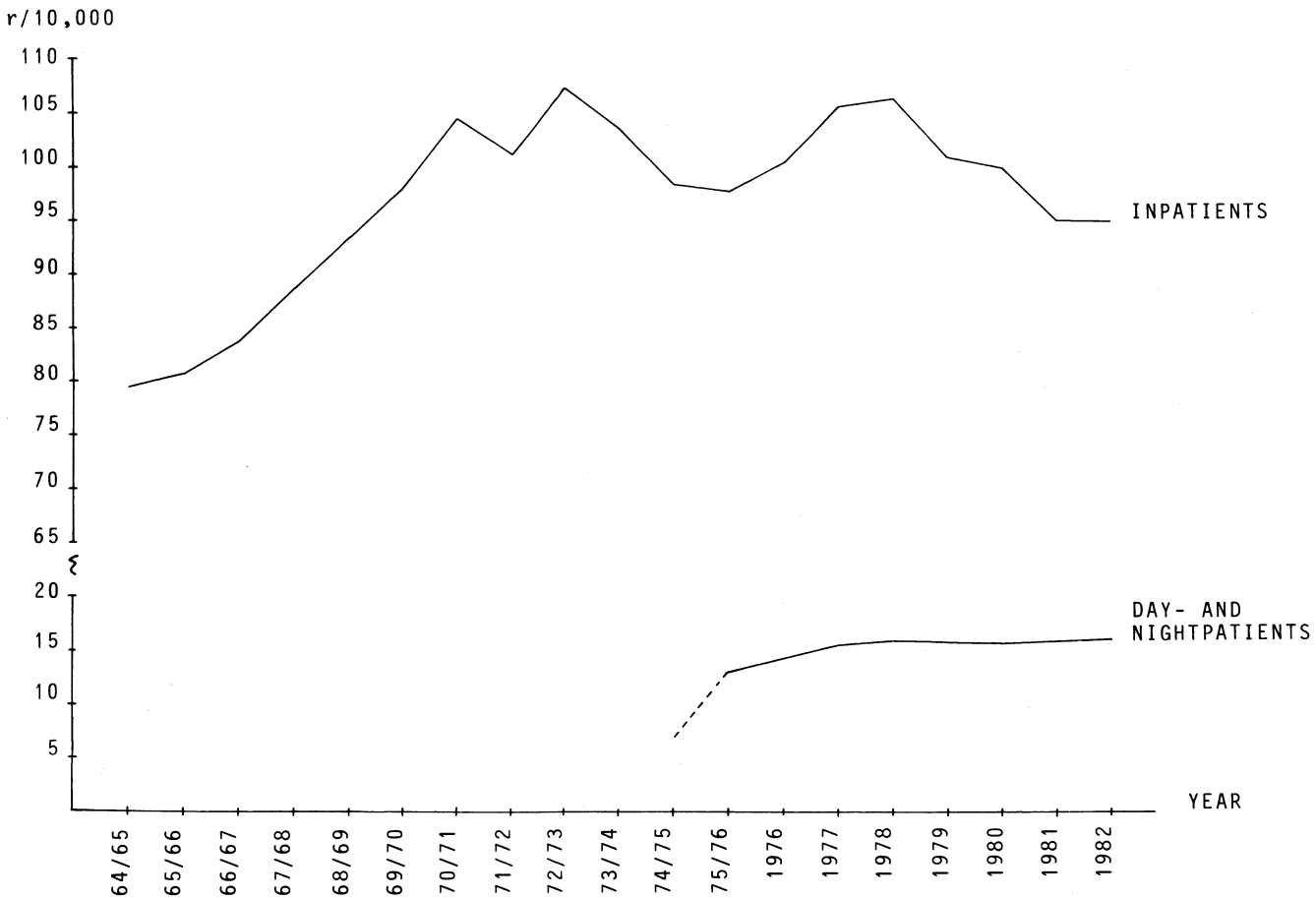

Fig. 1 Number of admissions of inpatients and day - and nightpatients > 15 years in psychiatric hospitals, departments and sanatoria per 10,000.

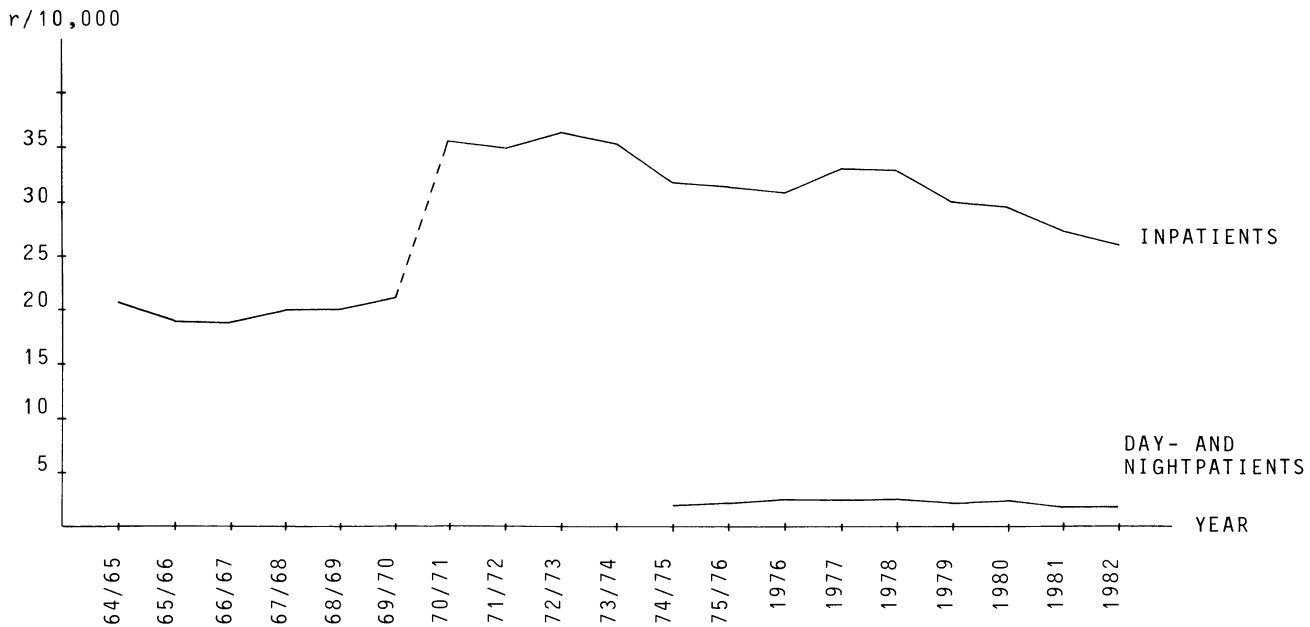

Fig. 2 Number of first admissions of inpatients and day - and nightpatients > 15 years in psychiatric hospitals, departments and sanatoria per 10,000.

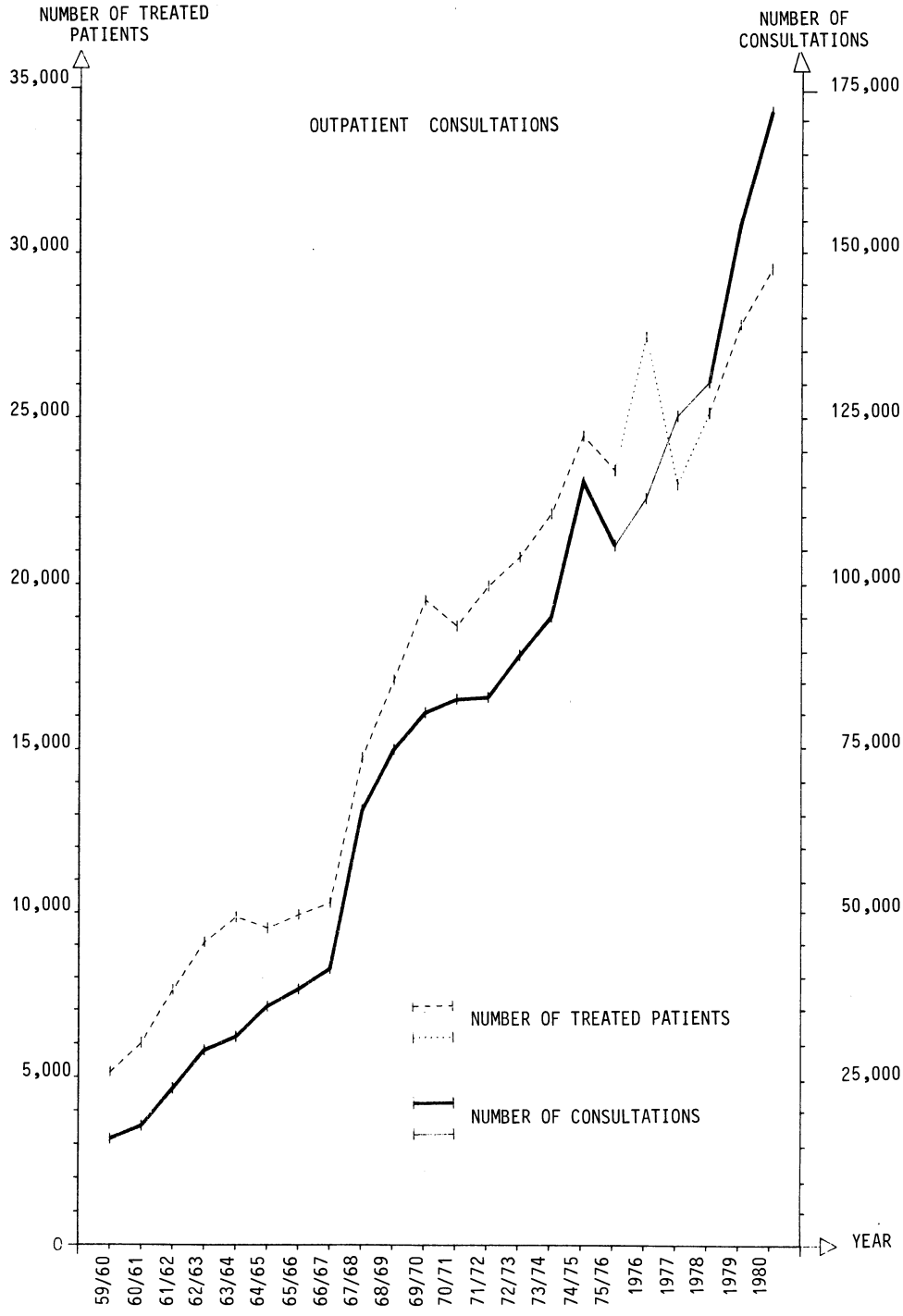

Fig. 3. Outpatient consultations

Table 4. Total number of admissions (inpatients), admissions/beds, and bed days/beds in ratios.

YEAR	ADMISSIONS INPATIENTS	ADMISSIONS/BEDS RATIO	BED DAYS/BEDS RATIO
1977	43,220	3.7	326
1978	43,854	3.8	322
1979	42,146	3.8	320
1980	42,065	3.9	318
1981	40,349	3.9	318
1982	40,364	3.9	314

If the features and trends for the whole country are studied, it is shown that the only way to reduce the number of admissions to hospitals is a reduction of the number of beds. The new trend with short duration of stay, reduction of old long-stay and new long-stay will lead to a reduction in the number of bed days. This is a function of the fact that the highest number of bed days is obtained by a chronically ill patient in the same bed from January 1st to December 31st. If the bed is used for a number of in-patient episodes, there will always be a certain "waste".

The out-patient service comprising both pre-, peri-, and post-admission episodes, consultations by psychiatrists in other wards (e.g., wards for neurology, medicine or surgery) and consultations and treatment at special out-patient clinics for alcoholics, etc., all these different out-patient activities have been established and function in many European countries (Giel and ten Horn, 1982; Lavik, 1983). A Danish census analysis from the Danish Pilot Study Area of the WHO European Study (Kastrup and Bille, 1980) has shown that with regard to age and diagnostic distribution the patients treated by private psychiatrists did not differ significantly from those treated at out-patient clinics.

There is a great difference between the total consumption of services if analysed from a hospital based view or from a total service analysis' view: Based upon the hospital analysis it is shown that certain groups of long-stay patients or often readmitted patients are using heavy amounts of the total services. (Dreyer and Dupont, 1978). Here it was shown that long-stay patients (comprising especially patients with organic disorders and schizophrenia) are carrying a heavy load in the total census material, in fact more than 50% of the total number of patients admitted on a census day. If compared with a 2-year analysis from a catchment area in Oslo (the above mentioned paper by Lavik) it was found that most of the total amount of all psychiatric patients were treated as out-patients, and an index based on weight points for in-patient treatment, out-patient treatment, and day-patient treatment, showed a very skewed distribution with 10% of the patients using 75% of the service resources. The whole pattern is very complicated, and as pointed out by Goldberg and Huxley (1980) it is important also to analyse the community services including the treatment in primary health services by general practitioners etc.

CONCLUSIONS:

The very simple planning where administrators wish to cut down the resources for one service according to the establishment of a new one, for instance establishment of some kind of out-patient service and hereby reducing the need for in-patient service, does not work. In many European countries the out-patient sector has been growing very much, and at the same time the demand for beds, including especially day care facilities, has been stable or in some cases growing. In some cases it is possible to conclude that new service

activities are establishing additional and better services for the groups previously untreated and thereby in some cases creating a new demand for beds and in-patient facilities.

REFERENCES

Brown, G.W., 1960, Length of hospital stay and schizophrenia: A review of statistical studies. Acta Psychiatrica t Neurologica Scandinavica, 35: 414-430.

Dreyer, K., and Dupont, A., 1978, Utilization of psychiatric beds. An analysis according to residence per April 1st, 1976. Medicinalstatiske Meddelelser, 1978:2, Sundhedsstyrelsen.

Giel, R., and ten Horn, G.H.M.M., 1982, Patterns of mental health care in a Dutch register area. Social psychiatry, 17: 117-123.

Goldberg, D., and Huxley, P., 1981, Mental illness in the community. The pathway to psychiatric care. Tawistock Publications, London and New York.

Lavik, N.J., 1983, Utilization of mental health services over a given period. Acta psychiatr. scand., 67: 404-413.

Kastrup, M., 1970, A nation-wide census of psychiatric out-patients in Denmark. Acta psychiatr. scand. 61: 245-255.

Kastrup, M., and Bille, M., 1980, A census study with special regard to long-stay psychiatric patients. Acta psychiatr. scand. suppl. 285, 62.

Nielsen, J., 1981, Patients from Samsø admitted to the Aarhus psychiatric hospital from 1852 to 1975. In: Nielsen, J., Nielsen, J.A., Kastrup, M., and Strömgren, E. The Samsø project. A community psychiatric project in a geographically delimited population. Acta Jutlandica LV, Aarhus; Medicien series 23.

Weeke, A., Kastrup, M., and Dupont, A., 1979, A long-stay patients in danish psychiatric hospitals. Psychological Medicine, 9: 551-566.

Weeke, A., and Strömgren, E., 1978, Fifteen years later. A comparison of patient in Danish psychiatric institutions in 1957, 1962, 1967, and 1972. Acta psychiatr. scand. 57: 129-144.

PREVENTIVE AND PROMOTIONAL GOALS OF COMMUNITY MENTAL HEALTH SERVICES

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INTRODUCTION

One of the important though frequently difficult tasks faced by community mental health organisations is that of identifying attainable goals. This is particularly true where such goals relate to primary prevention of psychological disorder, or promotion of psychological health. There is of course no simple model for prevention, given the complex causation of psychological disorders. A further complication is that activities directed toward primary prevention and mental health promotion have both idealogical and scientific aspects. "Community mental health ..... represents at one end of the spectrum a socio-political idealogy and at the other, an attempt to bring down-to-earth proven psychiatric practice in a more responsible way to the known or potential patients in the community".[1] This paper outlines attempts made by the Mental Health Foundation of New Zealand to define and implement preventive and promotional goals. For those less familiar with the Antipodes, before going on to outline specific Mental Health Foundation activities, I will mention a few basic facts about New Zealand society and the psychological needs with which community mental health services are confronted.

The relative geographic isolation of New Zealand meant that it was not settled until the mid 1800s. We now have a population of approximately 3 million, 90% of whom are of European, primarily British descent, most of the remaining 10% being Maori. Most of the population of Aotearoa, "the land of the long white cloud" as the Maoris named it, is spread over two long islands, with a land mass slightly greater than that of the United Kingdom. One hundred years ago approximately 80% of the population was rural.

However, the ratio is now reversed with approximately 80% living currently in urban areas. Despite an outdoor-oriented lifestyle, and a reputation for being "a good place to bring up kids", New Zealand society has its tensions, with widespread concern about an ailing economy, unemployment, industrial and cross-cultural tensions, and a sense of erosion of societal and personal stability. In terms of psychiatric disorder, what epidemiological data is available suggests that, as in other countries, 10-15% of the population have clinically significant psychological problems at a given point in time. Women out-number men 2:1 in presenting psychiatric problems to a general practitioner, and in admissions to psychiatric hospitals for neurotic disorders and depressive psychoses.

The Mental Health Foundation had its origins in a trust established in 1974. The stated objectives of the Foundation are "to promote by all practicable means the mental health and well-being of the inhabitants of New Zealand of whatever race, age, sex, class or occupation and to advance, especially in the areas of primary prevention, all measures designed or likely to prevent or reduce the incidence of mental ill health in the community". In 1977 the Foundation received $2.1 million from a national telethon. Telethons are held every year, or every second year in New Zealand and have become something of a national occasion. Fund-raising activities from one end of the country to the other are televised live over the 24 hours of the telethon and a strong appeal is made, by exuberant entertainers and public dignitaries, to support the cause to which telethon moneys will be donated that year. Through the 1977 telethon the Mental Health Foundation was publically committed to promoting community mental health activities, and mental health education and research. Not surprisingly, there is considerable public interest in how money donated through telethons is spent.

Since 1977 the Foundation has spent over $1.5 million on mental health activities. Approximately $850,000 of this $1.5 million has taken the form of grants to community organisations, over 400 grants in all, these being primarily to a wide range of community groups, most of which have chronic financial difficulties made worse by Government cutbacks. The remainder of moneys spent to date have been allocated for research, approximately $200,000, or the Foundation's own projects. With the pressure to disperse funds immediately following the telethon, the Foundation supported a wide range of community organisations. More recently, however, through experience with a range of programmes and organisations, and with decreasing financial reserves, the Foundation has defined priorities and objectives more tightly, and has focussed on certain service areas, needs, and social issues rather than others. More emphasis is now being placed by the Foundation on co-ordination between services and community groups, organisation of national

symposia on current mental health issues, advocacy to Government on behalf of voluntary agencies or in relation to matters such as current revisions of health education and mental health legislation, and liaison with the media in developing material designed to promote mental health.

The remaining sections of this paper will be devoted to an outline of certain areas of Mental Health Foundation activity, areas which illustrate both the evolution of the Foundation's activities and roles within the community, and also its struggle to translate into practical programmes an initially non-specific commitment to prevention and mental health promotion. The activities to be outlined are only some of those undertaken by the Foundation but are chosen to illustrate work directed toward the consequences and processes of family breakdown, support of women who might be considered at risk in New Zealand society, and efforts to promote awareness of the adverse effects of violence within the family and New Zealand society at large.

THE WOMEN'S REFUGE MOVEMENT

Approximately five years ago, as the first two women's refuges in New Zealand set about providing support for battered wives, there was considerable public hostility to their activities. The need for such refuges was questioned and the somewhat militant feminism of some founding members of the refuge movement was rejected by many in authority and within the health services. Nevertheless, considerable media coverage of the issue of domestic violence, and discussion within mental health services, emphasised that the level of domestic violence was much greater than many would like to believe, and that existing services, for a variety of reasons, were often unable to support the victims of such violence. The Mental Health Foundation sponsored a tour by Erin Pizzey, a founder of the Refuge Movement in Britain, and the concept of refuges was promoted through public meetings, media interviews and workshops. Subsequently, the Foundation gave grants to individual refuges in a variety of urban centres throughout New Zealand to assist with setting up and establishment costs. As those involved in administration of individual refuges came to recognise a need to clarify policy issues, and also to work closely with other services and agencies, the Foundation played a facilitative role in assisting the refuges to become incorporated as a national body, for co-ordination of fund raising, public education and other activities. The Foundation fulfilled a further advocacy role in helping the refuges obtain a national lottery grant, which the Foundation administered for the first twelve months on behalf of the refuges. In the last year or so the Foundation has been less actively involved with the Refuge Movement which has become a recognised part of the New Zealand mental health scene. However, the Foundation's concern with violence within the family has

continued as illustrated by recent sponsorship of a symposium on child abuse which drew together Government, hospital board and other services involved with child abuse, services the work of which tends to have been somewhat erratic and poorly co-ordinated. The symposium led to further discussion to improve services for abused children.

MENTAL HEALTH PROMOTION THROUGH TELEVISION

In addition to supporting the work of organisations attempting to meet the needs of those who have suffered violence within the family, the Foundation has attempted to promote, through the media, awareness of the ways in which the stresses and strains of family life may be handled constructively. Several television programmes have been developed, in conjunction with the national television network, to highlight stress points in family life, to illustrate constructive coping mechanisms and to emphasise that services are available for those requiring support. One such television programme, entitled "When the Bough Breaks" set out the story of a young mother with post-natal depression. Hospital and other records suggest the probability that post-natal depression is not properly identified or managed and, certainly at a broader level, New Zealand statistics indicate the early child-rearing period to be one of increased vulnerability for women. At the time of screening "When the Bough Breaks", the documentary was given considerable media coverage, pamphlets were produced for distribution to all general practitioners throughout New Zealand, and regional Mental Health Groups were provided with material for those wishing to discuss issues raised by the programme.

Another of the television programmes produced jointly by the Foundation and one of the national television networks was entitled "The Love and Marriage Survival Test". The primary aim of the programme was to encourage viewers to explore their own attitudes toward marriage, sex, love and family life. The programme, of 1½ hours duration, included documentary and dramatic sections but was also a participatory one, with studio audiences in two centres, Auckland and Christchurch, responding at certain points during the programme to questions in an attitude questionnaire which, with other material relating to the programme, had received wide publicity in the week prior to screening. According to a N.Z. Broadcasting Corporation survey, the programme was watched by close to 30% of the adult population in New Zealand, and received higher ratings than any other programme shown for approximately a month other than some editions of the network news. The Foundation also undertook its own evaluation, given the lack of research data on use of the media for mental health promotion. Individuals selected on a randomised basis from five major centres throughout New Zealand were contacted several days before screening of "The Love and Marriage Survival Test", and were invited to participate

in an evaluation of the programme. Fifty per cent of those approached indicated they would be free on the night of the screening and willing to participate. Of the 517 persons who agreed to participate in the evaluation, 335 (65%) returned evaluation questionnaires after the programme. Most viewers considered the programme to be quite informative and entertaining, and to a moderate degree challenging, though few considered it unsettling. A large majority considered that at least to some extent it had helped them in thinking about marriage in New Zealand society or their own marriage and close relationships. A highly significant age difference was found, with reported immediate impact of the programme on attitudes and decision-making processes being greatest for young adult viewers - a primary target group for the programme designers.

TELEVISION VIOLENCE CAMPAIGN

One further area of activity for the Foundation has been its monitoring of commercial television given the fact that television can influence the mental health of the community, and adversely affect certain vulnerable viewers. Over the last 18 months the Foundation has been involved in a campaign to reduce the level of violence on television, a campaign which has aroused considerable interest, has made mental health issues front page news, and has prompted discussion in the highest strata of Government administration and in Parliament. The Foundation has based its case on the fact that the link between television violence and subsequent aggression is one of the most thoroughly researched areas in the social sciences. There are now over 3,000 studies in the literature, most of which have been conducted in the last decade. Nearly all commentators on this literature agree that research has clearly demonstrated a causal relationship between violence viewing and aggression, particularly for young children and adolescents. While it is probable that boys who are inclined toward aggressive behaviour for other reasons are most severely affected by violence on television, television violence can and does affect normal children. The current level of violence on New Zealand television was established by a Foundation-sponsored Media Watch survey. Our current rate of 5.7 violent episodes per hour, when set alongside comparable figures from other countries, indicates that New Zealand is second only to the United States in the level of violence screened. To date, the N.Z. Broadcasting Corporation has been unwilling to acknowledge a link between television violence and aggression. The fact that mental health issues can become highly political is illustrated by recent events. The Foundation's report Violence on Television[2] was sent to the Broadcasting Corporation, as a courtesy, prior to public release, with an agreement by both parties that no comment would be made until the release date. Not only does violence on television promote aggression, but so too, apparently, does the reading by

broadcasting authorities of reports on television violence. Breaking the agreed-on embargo, the Broadcasting Corporation skilfully stole a march on the Foundation, attempting to discredit the report by completely distorting its findings, indicating that the Foundation's attack was directed primarly toward such beloved figures as Miss Piggy and Kermit from the Muppets, and the Pink Panther. Subsequently, the Foundation and one of the larger newspapers commissioned a national poll, a survey of 1,000 people throughout New Zealand selected using random sampling methods. Seventy-one per cent of those polled wanted to see less violence on television, compared to 62% in a similar poll two years previously, a finding which has been used for further press coverage of the issue. The debate continues and the Foundation will persist in its attempts to pursue what it sees as clearly a mental health issue.

CONCLUSION

It could be asserted that much of what has been described above falls outside the ambit of a symposium on "community mental health services in urban areas". Many of the Foundation's activities differ from those of services directed primarily toward patient care. Nevertheless, the principles which the Mental Health Foundation is attempting to implement are central to the community mental health "movement". First, there is a clear commitment to preventive activity, difficult though it may be to initiate and evaluate such work, and to primary and secondary, rather than tertiary prevention. Secondly, and arising from this, there is an attempt to identify "at risk" groups, and situations or stages in life when psychological vulnerability may be increased, and promote coping mechanisms appropriate to such groups, situations, or stages. Thirdly, recognising that the demand for professional mental health services frequently exceeds supply, and is sometimes inappropriate, the Foundation has made a deliberate attempt to facilitate the work of community groups and networks, and to use mechanisms, such as the media, by which to promote community awareness of and responsibility for mental health issues.

REFERENCES

1. G.L. Lipton, Community Mental Health as a Reality. Aust. N.Z. J. Psychiat. 14, 183 (1980).
2. H. Haines, Violence on Television, Mental Health Foundation, Auckland (1983).

INTEGRATION WITHIN THE MENTAL HEALTH CARE SYSTEM IN ROTTERDAM

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INTRODUCTION

In this introduction I propose to raise three themes. In the first place I want to go into the matter of the drastic changes taking place in the policy concerning the Health Care System in Holland. Next, I would like to mention the way in which this policy is implemented into the mental health care. Finally, I would like to elaborate the situation in Rotterdam, as this city provides us with an interesting case.

THE DUTCH HEALTH CARE POLICY

Radical changes in the policy of our national government have caused serious anxiety in Dutch health care. These changes in policy arise from a strongly increased political interest in health care problems. An interest especially aroused by the unmanageableness of the system and by a sharp rise in expenditure. Until recently, policymaking was in fact left to national organizations for professional workers, institutions and health insurance agencies. The Health Services Act, passed in 1982, transferred the responsibility for policy development in the health care field to political bodies, such as: the national government and provincial and municipal authorities.

Three ideas stand out in the Health Services Act:
Regionalization: the division of the country into regions in which a surveyable and coherent system of health care facilities is functioning.
Tiering: the ordening of these facilities to the level of specialization and the intensity of treatment.

Vertical de-centralization: the transfer of competence to lower authorities such as province and municipality and so allowing these lower authorities to develop the health policy. In this process the lower authorities have to bear in mind national criteria concerning maximum expenditure, criteria for planning and criteria concerning quality and organization of care. The financing of health care follows a separate circuit, managed and controlled at a national level. The structure of financing is such that it guarantees all citizens an equal accessibility, when nevessary, to all parts of the health care system.

POLICY CONCERNING MENTAL HEALTH CARE

More than 12% of our annual national health care budget is spent on mental health care. Intramural care alone costs approximately three billion Dutch guilders*; semi-mural and non-residential care each about 300 million Dutch guilders. The non-residential care in particular, has drastically been reconstructed during the last two years. Until recently, a 120 institutions operated in this field, each comprising one or more of the classical specimen of non-residential mental health care, such as: child guidance centres, (equivalent medical pedagogical services), social-psychiatric services, services for psycho-social and existential problems and institutions for psycho-therapy. From the first of January 1982, all these activities were brought together under the Exceptional Medical Expenses Act. Through this measure, non-residential mental health care became a right guaranteed to all citizens of our country, without individual payment for treatment or care. This measure, in essence a financial one, has been used by the national government to regulate non-residential mental health care.

The country was devided into 60 regions. In each region the already existing institutions had to form a new regional organization with one management responsible for all specimen of non-residential mental health care which I have mentioned before. Such a new regional organization only, was officially recognized; which means: only these new regional organizations were financed by the national government through the Exceptional Medical Expenses Act. Through this process of reconstruction, the existing institutions were forced, by the central government, to merge. It is true that for some years the non-residential mental health care sector, on its own initiative, has been engaged in a process of integration. Because of the slow advance made, it is only fair to state that regionalization and integration of this sector of health care has been completed through heavy pressure from the side of the national government, up to now a unique fact in the Dutch history

*(3 Dutch guilders = 1 $)

of health care development. In the non-residential mental health care some 2,500 professionals are employed, almost equally distributed over the disciplines of psychiatrist, psychologist, social worker, and social-psychiatric nurse. The above mentioned regional reconstruction of the non-residential health care has to be considered as a first result of the policy aimed at regionalized care as formulated in the Health Service Act. The second phase of reconstruction is to be carried out now; that's to say: the formation of regional institutions for the total mental health care, including non-residential, semi-mural and intra-mural care. As a consequence of this, general psychiatric hospitals have to take responsibility for a specific catchment area consisting of a region equal in all respects to the catchment area of one or two institutes for non-residential health care. In such a region, semi-mural care too has to be united into one organization. It is still an open question wether this new regional system for the whole of mental health care should consist of one organization formed by merging of the existing facilities or of a institutionalised co-operative structure.

According to me, the process of merging everything into one organization may paralyse a normal development. A great number of problems still has to be worked out. In the extra-mural care there is the problem of the co-operation between institutions for non-residential care, outpatients services of psychiatric hospitals and neuro-psychiatrists in free practice. Over and above this there is the great problem how to reduce the capacity of the intra-mural care in order to open up financial capacity for the strengthening of non-residential and semi-mural care.

It is preferable, in my view, to arrange non-residential care and the intra-mural care as two mutually stimulating counterparts within the dynamic relationship of a co-operative structure. A recognizable non-residential care is necessary as a stimulus for the hospital not to run aground in the process of reconstruction. As many vested interests are at stake, such as job-security, status, professional opinions and convictions, this stimulus will probably be indispensable when intra-mural care has to be gradually diminished. The intra-mural care however may save the non-residential care from a slow decline towards a sort of welfare institute primarily concerned with psycho-social care. The danger of such a decline is a real one in The Netherlands.

A policy aimed at reducing the capacity of psychiatric hospitals makes it necessary for non-residential care to focus itself on social-psychiatric aid as well. After perhaps five to seven years a second stage of development can be reached, the construction of óne organization for mental health care.

MENTAL HEALTH CARE IN ROTTERDAM

Rotterdam (in size the second city in the Netherlands) is relatively young. In 1850 the city had less than 100,000 inhabitants; in 1920 approximately 320,000 and in 1965, 750,000.

At the moment there are 570,000. The sharp decline of the last years has come to a halt. The number of inhabitants is stationary at the moment. However, there is a slow tendency towards increase because of a carefully aimed housing policy. In the 1920's housing conditions and the state of health of the population were rather poor, even when compared to cities such as Amsterdam and The Hague. At that moment tuberculosis was still the major cause of death. The bombardment of the old inner city, in May 1940, had various consequences. The major consequence of the destruction was perhaps the disappearance of the old inner city centre; the need for rebuilding was a great challenge; it allowed the typical Rotterdam mentality, well-known in The Netherlands, to become prominent: spirit of enterprise, zest for work and a thorough dislike of bureaucracy.

In the Rotterdam area there are 1,1 million inhabitants; 800,000 of them situated in a densely populated urbanized area. In this area the world's biggest port is situated bringing along with it huge environmental problems into the bargain.

In the present day population the following changes are perceptible: an increase in the number of aged people (at the moment 16% of the population); a fast growth of the proportion of inhabitants belonging to ethnical minorities (at the moment 11% of the population); and a rise of the number of long term unemployed and people depending on social benefit (at the moment 20% of the population).

For the benefit of the Rotterdam area, three general psychiatric hospitals are in operation. In the region itself there is one psychiatric hospital, an old building with 850 beds; it should be renovated completely. The second institute is to be found near the edge of the region (in the historical city of Delft) and will provide the Rotterdam region itself with another 200 beds. The third psychiatric hospital is, at the moment, situated at a distance of 45 km from Rotterdam but, after a renovation, it will be transferred to the Rotterdam region adding another 300 beds to the area. In the semi-mural care there are about 350 places. Until recently, the non-residential care was hardly integrated at all. In the framework of the national reconstruction of non-residential care, six institutes have been formed for the Rotterdam area; four of which for the benefit of the town and its direct satellite municipalities.

All institutes and organizations working within the field of

mental health care in the Rotterdam region take part in a collective consultation. In this consultation efforts are made to reach agreements on policy development and a further co-ordination of care. A strong impulse for this consultation originated with the workshop organized in 1980 under the auspices of the World Health Organization. The specific subject of this workshop was the development of mental health care in cities as Rotterdam. In fact, the greater part of the participants consisted of managing-directors of Rotterdam institutions. The contribution of international experts, the efficiency of the regional office of the World Health Organization, but above all the hospitable atmosphere in Copenhagen (the Tivoli-park has played an important role in this conference) provided a condition in which the responsible managers were able to disentangle themselves form every day problems and were able to arrive, collectively, at formulating the principals for a future policy.

In these principals regionalization of health care, in the Rotterdam area, was a central issue. Prof. B. Cooper form Mannheim University wrote an excellent report on this conference. As it is not yet cleared by the Dutch government, it has still the status of a confidential report. However, copies are available in Rotterdam.

The development which is to be expected links up with these principals. In the non-residential care institutions have been set up with regional responsibility. There exists a system for non-residential emergency care, 7 x 24 hours. At the moment a policy concerning a further regionalization is being worked out. It aims at a primary working area for each psychiatric hospital, a collective policy development in this area for non-residential health care, semi-mural care and the psychiatric hospital, diminishing of the intra-mural capacity to 0.9 per one thousand inhabitants, renovating and building up of intra-mural psychiatric care in decentralized small scale institutions, which means:

- a relatively small sized clinic with some 200 indoor patients;
- city-key-points spread over the area which have the following functions:

1. an out-patient's department
2. a crisis intervention centre
3. day treatment
4. day or night care
5. shortterm treatment

(20-30 beds)

(Most of these facilities are available at the moment within the context of the stigmatising, large intra-mural institutions). The organization and staffing of these city-key-points are to be worked out instead of classical intra-mural beds, in close co-operation with the non-residential care. Part of the intra-mural capacity has to be transformed in hostels and sheltered homes. These facilities

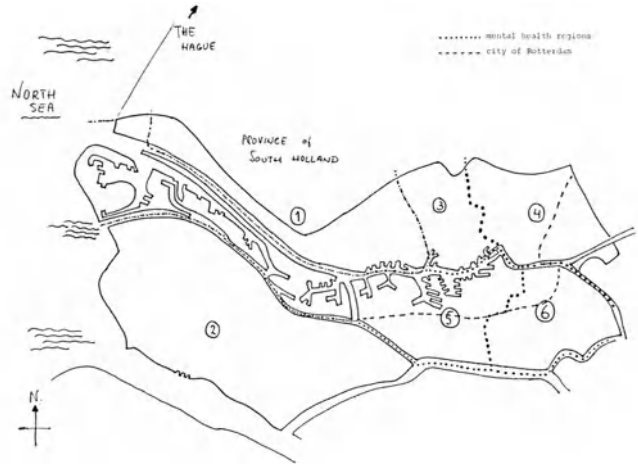
are, especially in large cities, necessary in a comprehensive care system. In my view it is essential that the intra-mural institutions transfer the responsibility for these facilities to organizations for semi-mural care. Parallel to this proces of reconstruction, work has already begun to set up such projects as a joint information centre.

At the moment, the development is somewhat at a low ebb, consequent also to the financial problems of the treasury. In this way the necessary renovation of psychiatric hospitals is strongly temporized. A new impuls might originate with the municipal

TABLE 1. MENTAL HEALTH REGIONS AND POPULATION DISTRIBUTION

Region	Number of inhabitants
1. Waterweg Noord	190.000
2. The Islands	210.000
3. Rotterdam Centre West [1)]	170.000
4. Rotterdam North East [1)]	230.000
5. Rotterdam South West [1)]	200.000
6. Rotterdam South East [1)]	135.000

1) These regions comprise the city of Rotterdam and 6 suburbs.



authorities who in the framework of the new legislation will receive explicit competence to develop future plans. In a system of consecutive four-year plans a further co-ordinated development of mental health care will be stimulated and taken up by these authorities, in close co-operation with all parties involved. In this planning-process the municipal authorities of Rotterdam will, I hope quarantee that a clear policy will be implemented, aiming at a client centered care.

TABLE 2. MENTAL HEALTH FACILITIES IN THE ROTTERDAM AREA

		Professional manpower (full-time equiv.) - m - or beds - b -	
A/F	Institutes for non-residential mental health care:		
	A Waterweg Noord	20	- m -
	B The Islands	20	"
	C Rotterdam Centre West	35	"
	D Rotterdam North East	45	"
	E Rotterdam South West	35	"
	F Rotterdam South East	20	"
	G Delta psychiatric hospital	± 850	- b -
	H Bavo " "	± 300	"
	I Joris " "	± 250	"
	J Dijkzigt hospital (psych.dep.of University)	85	"
	K Psychiatric dept. Schiedam, gen. hospital	50	"
L/P	Hostels/sheltered homes		
	L Pameijer	165	"
	M Zuidbuurt	20	"
	N Rustenburg	70	"
	O Hillevliet	15	"
	P Bavo	25	"
Q	Centre for crisis intervention	5	"
R/S	Child psychiatry		
	R Sophia Children Hospital (University)	15	"
	S Psychiatric Hospital for Children	25	"
T/V	Care for addicted people		
	T Bouman hospital	138	"
	U Bouman non-residential care	65	- m -
	V Rehabilitation projects, methadon projects		

TABLE 3. HEALTH CARE FACILITIES AND CATCHMENT AREA
(Mental health region)

Facilities (see table 2)	Mental health region (table 1)					
	1	2	3	4	5	6
A, I, K, M	x					
B		x				
C			x			
D				x		
E					x	
F						x
H, H, P			x	x		
O					x	x
G		x			x	x
Q, V			x	x	x	x
L		x	x	x	x	x
J. R, S, T, U	x	x	x	x	x	x

TABLE 4. MANPOWER DISTRIBUTION IN INSTITUTIONS FOR NON-RESIDENTIAL MENTAL HEALTH CARE IN ROTTERDAM
(Full-time professionals, 1.12.1982)

	Centre west	North east	South west	South east	Total
psychiatrist	9	7	9	4	29
psychologist	11	16	9	2	38
social worker	8	19	7	9	43
social psychiatric nurse	9	4	11	5	29
Total	37	46	36	20	139

TABLE 5. NON-RESIDENTIAL CARE IN THE REGION CENTRE-WEST: TEAMS FOR CHILD-CARE, ADULTS, AGED PEOPLE AND FOR PSYCHOTHERAPY

	Children	Adults	Aged people	Psycho-therapy	Total
psychiatrist	2	3	1	3	9
psychologist	4	2	1	4	11
social worker	4	4	-	-	8
social psychiatric nurse	1	5	3	-	9
Total	11	14	5	7	37

TABLE 6. KEY FIGURES CONCERNING MENTAL HEALTH CARE IN ROTTERDAM (31.12.1982)

	Centre west	North east	South west	South east	Total
psychiatric admissions in mental hospitals	460	340	460	150	1510
admissions in clinics for addicted people	260	180	210	40	690
compulsory admissions	-	-	-	-	220
psychiatric admissions per 1000 inhabitants	2.6	1.5	2.3	1.1	2.1
professional non-residential care (hours per week per 1000 inhabitants)	9	8	7	5	

COMPARISON OF "OLD" AND "NEW" LONG-STAY PATIENTS

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Generally it is taken for granted that there are indeed too many long-stay patients in the mental hospitals and everything possible should be done to reduce their numbers.

On the basis of this thinking, many countries, including the Netherlands, started a more or less fundamental restructuring process of the mental hospitals.

After everything has been said and done the mental hospitals will be able to treat 15000 patients. At the moment there are about 22000 patients in the mental hospitals.

This policy makes it imperative to take an extreme interest in the problems concerning the long-stay patients. One of the most important questions being, whether the number of long-stay patients in the hospitals will increase or decrease in the future.

In this paper data will be used, derived from the central case register for mental patients in the hospitals.

It's important to note that the capacity of mental hospitals is mainly influenced by changes in mental health care outside the hospitals. In other words the capacity depends on other mental health provisions suitable for the chronic psychiatric patients.

For example : the number of oligophrenics in the mental hospitals in 1980 was reduced to one third of the numbers in 1970, while the therapeutic results haven't changed much.

The only explanation for this is the building of more special institutions for the oligophrenics.

Old long-stay patients are usually described as psychiatric patients who have been treated continuously in the mental hospital for a given period of time and longer. Usually the period of time chosen is two years. Personally I prefer a period of three years, because a small but substantial number of patients is discharged between two and three years.

In 1980 the Dutch mental hospitals counted 21.254 beds.
In the same year 18.558 patients had been discharged.
90.2 % left within one year.
5.8 % left within one and two years.
1.5 % left within two and three years.
0.6 % left within three and four years.

Of the 21.254 patients at the end of 1980, 53.4 % belonged to the old long-stay population with a length of stay longer than three years.

43.8 % of the old long-stay patients is 65 years of age or older.
30.3 % of all patients in the mental hospitals at the end of 1980 had been staying there for 15 years or longer.

Every year a number of old long-stay patients leave the mental hospitals in one way or another.
- 1098 long-stay patients, that is 8.8 % of the long-stay population left in 1980
- 633 deceased
- 251 were transferred to other mental health institutions
- 214 left for home or family.

The old long-stay population can be considered as a system. Yearly a number of patients leaves this system. In this way beds for new long-stay patients become available.
In the present situation a little more than 1000 patients can be absorbed yearly in the long-stay sector without causing the mental hospital to grow.

An old long-stay patient has an average length of stay of 11.5 years. Also more than 50 % of the mental hospital patients belong to the old long-stay population. So it stands to reason that a considerable yearly reduction in the number of new long-stay patients is of great significance in reducing the capacity of the mental hospitals.

For example : an estimated 1000 new long-stay patients every year means 11.500 beds in the hospitals are needed. A yearly reduction of new long-stay patients by half would eventually

result in a reduction of the capacity with 5.750 beds.
So it is indeed of the utmost importance to decrease the number of new long-stay patients.

New long-stay patients are those who, after admission in the mental hospital, stay there for 3 years continuously and then join the old long-stay system.
The available data show that every year about 4-5 % of the admitted patients will eventually be long-stay patients. The figures show 20.163 admissions, readmissions included, took place in 1980.
So there are less new long-stay patients than the yearly available places in the old long-stay system.
This could indicate the possibility of a slight yearly reduction of the total capacity of the mental hospitals, other variabilities excluded.
However, in the past few years there has been no reduction any more. To explain this, we'll have to look at the admissions. Yearly the total numbers of admissions grow. This is illustrated by the following figures :
in 1970 : 12.829 admissions
in 1980 : 20.163 admissions.
In these 10 years the capacity of the mental hospitals has already been reduced from 26.000 to 22.000 beds; this mainly as a result of external circumstances.
More patients are admitted and readmitted, but the average stay is shortened considerably. At the same time there has been a shift. Slowly more and more former long-stay beds will be utilised as short-stay beds.
The new long-stay patient is elusive in the case register, because in many cases, there is no continuous intramural psychiatric career.
In the course of many years again and again one tries to discharge the chronic psychiatric patient. After some time a readmission becomes necessary. Quite often this situation repeats itself many times. Therefore it's not surprising that the number of readmissions increased considerably.
In 1970 : a readmission index of 100 and 1.559 readmissions.
In 1980 : a readmission index of 212 and 3.306 readmissions.

This understandable policy of the mental hospitals results in a very long but intermittent psychiatric career. The patient simply doesn't get the chance to become a new long-stay patient. This somewhat ridiculous observation is possible, because the old long-stay patient and the new long-stay patients are artificial notions.
The mental hospitals have two functions, which aren't recognisable as such. In fact there is a hospital or clinic function and a psychiatric nursing-home function. Since this distinction hasn't been made, the cure-patients and the care-pa-

tients are not recognisable in a registration system.
It would be advisable for those functions to be practised in separate organisational forms. Psychiatrically speaking, this is also the sensible thing to do, because cure-patients need a totally different therapeutic approach than the care-patients.

In the mental hospital everything should be done to reduce the numbers of new long-stay patients. There are, however, signs indicating a possible increase of new long-stay patients in the near future.
The register shows 3.175 patients with a length of stay from 2 to 5 years in 1970 and 2.638 patients in 1980 were present in the Dutch mental hospitals.
26.2 % was classified as schizophrenic in 1970 and 20.9 % in 1980.
Perhaps this signifies the possibility of treating more schizophrenics in society.
- 3.9 % were classified as neurotic conditions in 1970 and 9.8 % in 1980. This significant increase happened, notwithstanding the development of primary day-treatment facilities, more ambulatory care and a striking expansion of psychotherapeutic treatment facilities.
- 5.4 % were classified as personality disorders in 1970 and 9.8 % in 1980. Although it is said there is a growing aversion of the traditional psychiatric hospital, the figures don't support those ideas.
- 2.5 % were classified as addicts in 1970 and 7.5 % in 1980. It seems certain this percentage will rise more and more in the following years. The consumption of alcohol is still rising fast in the Netherlands.
- 14.2 % were classified as mentally retarded in 1970 and 4.9 % in 1980. The reason for this has been discussed earlier.

Although there are more chronic psychiatric diseases owing to the ageing of the population in general, this isn't reflected in the increase of new long-stay patients, since these patients are transferred to psychogeriatric nursing-homes as soon as possible.

In order to prevent the development of new long-stay patients, the chronic mental patients will have to be discharged as soon as possible. The transfer to psychiatric hostels, half-way homes and boarding houses is the most likely solution.
It is disappointing however, to note that as yet only a small number of patients is indeed transferred to these semimural institutions.

The semimural institutions in the Netherlands have about 2500 beds available. It seems that the average length of stay

is about 5 years. The available beds are being used for only a small part by patients discharged from mental hospitals. They are for an important part directly used by chronic mentally disabled persons directly out of society. This may prevent indirectly an increase of the long-stay population in the hospital.
In the Netherlands it's intended to double the capacity of the semimural institutions. At the same time the number of beds in the mental hospitals will be reduced with some 2000 beds.
Of course these ambitious plans have to be implemented carefully and it will presumably take many years. This program should enable the mental hospitals to reduce the number of new long-stay patients, although a substantial decrease of old long-stay patients cannot be expected.
Of course it's possible to discharge many more old long-stay patients forcibly. This shouldn't be done. If the so discharged patients are obligated to live in psychohygienic appalling conditions, the cure is worse than the ailment.
If an old long-stay patient is discharged, there has to be a reasonable expectation the patient will be better off in his new surroundings.

In the Netherlands there is a growing conviction, that one shouldn't try to meddle around too much with the very old long-stay patients, aside from bettering their housing- and living conditions in the mental hospital.

As said before, there are indications, the mental hospitals will have to cope with new categories of long-stay patients, especially the addicts with cerebral damage, patients with severe neurotic conditions and with personality disorders.
There is, however, the understandable wish to do everything possible to prevent hospitalisation as much as possible and preferably altogether.
The negative side-effects of hospitalisation are perhaps too much feared these days.
Chances are the aforementioned patients will be treated for many consecutive years in society with ambulant care. There is the distinct danger, those patients will receive too long a low-care treatment. They may be kept out of the hospital for such a long time, that if the admission becomes necessary after all, it's extremely difficult and even impossible to cure them. By avoiding the mental hospital, new long-stay patients are produced. This very fascinating hypothesis has to be studied very carefully.

As mentioned before it's usually thought that about 5 % of the admitted patients in the mental hospitals will eventually become new long-stay patients.

It could be this percentage gives rise to a wrong impression. More and more patients are admitted every year in the mental hospitals. Therefore the percentage of new long-stay patients must go down even if their numbers stay the same.
In 1978, 1979 and 1980 the percentages of new long-stay patients (3-4 years in the hospital) increased, namely 3.7 % --- 3.8 % --- 4.2 %. This percentage was calculated on the basis of the total number of the patients.
If the percentage is calculated on the basis of the total number of admissions, readmissions included, there don't seem to be any changes, namely 4.1 % --- 3.9 % --- 4.1 % in 1978, 1979 and 1980.

Now these figures are somewhat distorted. In the register the traditional mental hospitals are registered as well as some psychiatric clinics, that have no long-stay patients at all. If only the traditional mental hospitals are taken into account, the picture is somewhat different.
Of the patients admitted in 1978 out of other psychiatric institutions 13 % were still in the hospital at the end of 1980. Of the patients admitted in 1978 directly out of society, 4.8 % were still present at the end of 1980.

So it seems the ever rising numbers of short-stay patients camouflage the slowly rising numbers of new long-stay patients.
Time wouldn't be wasted, if some research on this phenomenon could be done. At the same time calculations like this show their inadequacy. It would be much better, if the long-stay patients were diagnosed as such and then registered, independant of the length of stay in the hospital.

It is important to emphasize the fact that the problem of the long-stay patients can only be solved if a consistent and permanent interest is garanteed. There has to be a continuous willingness to spend time, money and manpower on the problem. Optimal treatment of chronic mental patients isn't cheap, neither in nor out of society.

THE POLITICS OF COMMUNITY CARE

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INTRODUCTION

Legislative measures and societal attitudes in the developed countries (and insofar as they follow suit, the developing countries) have over the last twenty-five years demonstrated a curious contradiction and ambivalence in relation to the provision of after-care services for mental hospital patients and preventive care for those at risk.

AMBIVALENT LEGISLATION

On the one hand there has been a positive response to optimistic "enlightened" and exciting findings regarding the relative normality of patients, and their ability and right to be integrated into society. In a number of countries these findings have resulted in legislation requiring statutory bodies, responsible for local health and social services, to ensure the availability of a range of facilities which can replace the large institutions and provide "the least restrictive setting" combined with appropriate social and medical support for those considered able to live outside the mental hospital.

On the other hand, such legislation has not addressed itself to the needs, which go hand-in-hand with the rights, of those considered capable, after a period of rehabilitation, of taking their place in society. Such needs include the formulation of a personalised plan for rehabilitation, including access to a halfway house or therapeutic community - a facility which is by right established in a residential area - and having the cost of such facilities by right met by the government or the appropriate insurance carrier.

Insofar as needs and rights have been addressed by legislation, escape clauses have formed an indissoluble part, by design or default. For example:

In the U.K., the Mental Health Act 1959[3] - at the time considered a major step in the direction of "care in the community" - allowed the powers of local authorities for provision of community services for the mentally ill to remain permissive, unless the minister gave a directive (under section 28 of the 1946 National Health Services Act). In 1974, the Secretary of State, using the powers vested in him (by the Health Services and Public Health Act 1968), directed local authorities 'for the purpose of the prevention of mental disorder or in relation to persons who are, or have been, suffering from mental disorder...to provide residential accommodation (including residential homes, hostels, group homes..) and the care of persons for the time being resident in accommodation so provided.' However, whilst the Secretary of State is vested with statutory powers to declare local authorities to be in default, and to take steps to enforce the remedying of such default, successive incumbents of that post have shown a marked reluctance to take any such step, despite officially acknowledging the poor record of local authorities in this vital respect. The then Secretary of State, David Ennals, in a conference in 1976, emphasised the need for public pressure on local authorities for the implementation of the shift to community care, thus evading his own responsibility, and depriving the public of a potentially effective means of applying pressure, i.e. legal redress against the authorities enforceable in the courts.[1]

The 1975 White Paper, Better Services for the Mentally Ill,[4] made little headway in financial terms, although it made progress in the direction of administrative efficiency; it set "minimal standards" for a variety of community services, but conceded that it might take a generation before even these standards would be met. The present government can therefore take heart - and "take a generation!" An obvious loophole is to put the "recoverable" mentally ill at the mercy of their fellow men, expecting those governed to be more decent than their government. At a conference, held in January 1981 at Swanwick, Sir George Young (then Parliamentary Under Secretary, Department of Health and Social Security) said: 'I have no doubt that the time is ripe for developing local voluntary action; people are more aware than they have been for a generation that there are and should be limits to what the government will provide.' He then made the unrealistic suggestion that if 'the people themselves' care, they will provide not only the services but funds to run the services, without relying on monies derived from taxes or rates. Such statements cast doubt on the intentions of government as well as on their appreciation of and support for the voluntary sector, which cannot ad infinitum be expected to carry not only the cost of initiating programmes, but the burden of recurring expenditure.[2]

There is no doubt that similar examples of halfhearted legislation and implementation can be quoted from other countries which, at one time, appeared to take the need of the mentally ill or those at risk seriously. The Report of the President's Commission on Mental Health (USA, 1978)[5] was outspoken about the 'deplorably inadequate' existing provision:

'Time and again we have learned - from testimony, from inquiries, and from the reports of special task panels - of people with chronic mental disabilities who have been released from hospitals but who do not have the basic necessities of life. They lack adequate food, clothing, or shelter...While not every individual can be treated within the community, many of the readmissions to State hospitals could have been avoided if comprehensive assistance had existed within their communities.'

The "American Ailment" - the struggle for kudos and control at the expense of collective action - may make provision in the community more difficult to achieve than elsewhere, but almost everywhere (and governments can and do hide behind this) there is a lack of co-ordinated action, and provision is sparse, disjointed, hard to identify and incapable of being financed. Legislation has remained vague, unimaginative, lacking in will and decisiveness, and has most certainly encouraged the view that whatever else is necessary in a civilisation, the opportunity for mental patients to achieve integration with the community is not! The consequences, depending on the country concerned, are: retention of the status quo, with very little discharge from hospital; indiscriminate discharge, frequently with disastrous episodes for the patients, their families or the neighbourhood, and a problem-ridden emergence of alternatives to hospital, which are under-resourced in terms of finance, manpower and expertise.

A WEAK LOBBY

The legislative contradictions and the low priority given to preventive mental health and aftercare may be seen in terms of the ambivalence of society as a whole in relation to one of its products - for a century and more seen as waste. Society is reluctant to reconsider its solidarity with, and responsibility for, and liability to become a member of, this unfortunate segment of the human race; a segment which tends to be anxiety and guilt provoking, and therefore best left alone. Such attitudes, observed (and shared) by government, become a godsend when the search for economic cuts is on! A strong 'consumer' body could defend itself against being the target of cuts. Although a proportion of patients could constructively and capably contribute to a lobby, attempting to 'rally' the mentally ill could amount to unacceptable manipulation. In general, the mentally ill are not mobilised to speak for themselves, not represented by their families because they are overwhelmed or embarrassed, and not lobbied for by community services because of their weakness relative to the hospital service, and

their (often self-imposed) isolation from related services. With the existence of a vocal unwelcoming community and in the absence of a vocal and persuasive group of allies, the mentally ill will remain at the mercy of ambivalent legislation.

Governments will, for financial and other reasons, instead of making inescapable stipulations for minimal standards of care and the right to live and be helped to live in the community, hide behind a world recession or even protect the rights of the community to reject "invaders" who would wish to join its mainstream.

MENTAL HEALTH SERVICES AS INDUSTRY

Another complicating factor is that the mentally ill are job providers. The move away from institutions, especially where it concerns the more interesting and "rewarding" patients, constitutes a loss in job satisfaction and a potential loss of the whole industry. Especially in the large institutions with powerful unions, and amongst professionals who, traditionally, have been looked to as the experts, e.g. the psychiatrists, there often exists an understandable reluctance to "let go" when a patient is ready to go. This reluctance is frequently shared by the patient and his relatives, even where the major problem is not "illness" but malfunctioning due to identifiable social stress and associated emotional distress, capable of being resolved through exploration and adjustment. Illness is often the only sanctioned role in which a person can be dependent and vulnerable. When normal networks fail to provide support during a crisis, there is usually no facility outside the medical (or penal) system which can receive the distressed person. For individuals who feel unable to resolve a painful conflict (for example, to choose a morally right course of action in a potentially damaging situation),who cannot cope with the loss of the most significant person in their life, or who question the sense of living in a world which has become too painful, the only options may be to "grin and bear it" in isolation, to commit suicide or to convert their needs into the acceptable condition of illness.

A substantial proportion of mental ill health falls into this category, and can better be addressed by a psycho-social than by a medical approach. The question arises: when and/or at what point is one approach called for rather than the other, and where must they go hand-in-hand. In many instances different patterns of service can equally well meet the need, or equally badly, as the existence of services does not guarantee that individual needs are met flexibly. The debate on mental hospital and medical services versus community and psycho-social services, a debate which tends to be plagued by vested interests and tradition-bound views, needs to elucidate some simple issues:

What services could prevent people from falling victim to stress and distress, leading to emotional or mental breakdown.

What services should be developed to help those who have broken down, to prevent hospitalisation, or relapse.

What services are needed within the local hospital to prevent admission to the large mental institution.

How can the large mental institution be humanised so that it caters for the needs of inmates (and not primarily for the needs of staff - an ill which appears to exist to a larger degree in the larger and less personal institution than elsewhere), so that it can, at the earliest opportunity, refer its charges back to facilities where greater independence and integration can be furthered.

What administrative and funding adjustments are needed to facilitate movement between services as appropriate for the consumer.

Answers to these questions will have one common denominator: all these services, whether medical or psycho-social (or, for that matter legislative and administrative), need staff with a particular understanding of the situation in which the individual in distress finds himself, a creative involvement in his predicament and search for solutions, and the availability of a range of facilities to which one can refer. In both services, staff with the appropriate qualities can be found, but both services do not equally well serve all those in need indiscriminately; furthermore, facilities for those who make good progress are conspicuous by their absence, and "the next step" is therefore discouraged.

In addition, each discipline has its particular basic expertise to offer and it would be foolish not to ensure that, in hospital services, nursing and medical skills are used to the full; similarly, that social skills and the wish to work outside the hospital are utilised in the domiciliary care of (ex-) patients, in need of on-going medication (e.g. injections) as well as support. Strengths must be utilised to the full, whilst opportunities need to be given to those staff who have the desire and potential to move from one service to another. Of necessity, this will usually mean that certain nurses will be selected and trained to become community psychiatric nurses or to take on therapeutic and counselling roles in community services, which could impoverish and/or demoralise the hospital staff as such.

It has been suggested, at the time of the 1959 Mental Health Act (U.K.) and since, that patients and their carers could move together from the hospital to alternative facilities. Such moves, whilst meeting the need for redeployment of hospital staff and ensuring continuity of care for the patients, would not usually be in the interest of the latter, unless they were chronically and severely dependent, or unless the nurses were particularly sensitive to, and able to counter, the traditions and expectations normally associated with mental illness and hospital life. It must be obvious that the very acute, the more chronic and the more disabled and aged, will increasingly constitute the core of the hospital population

although, in future, their life may be lived in smaller-scale units. The pressures exercised by governments to make the long-term disabled (often geriatric patients who by now feel "at home" in the hospital) a priority for care in the community, whilst ignoring the needs of those capable of using help and of contributing once again to society, is another example of administrative contradiction, which can be more readily understood in terms of financial expedience than as a rational and caring framework of selection.

AMBIVALENT PSYCHIATRY

Burke's statement that "All that is necessary for evil to triumph is for good men to do nothing" is not entirely irrelevant where the psychiatrist is concerned. Whether his expertise is relevant to the situation in which a particular patient finds himself or not, he is in a powerful position in the hospital, the family and the administrative and political arena. In community psychiatry, his expertise in relation to the patient per se is likely to be recognised and utilised. His usefulness to the staff group of a community facility in understanding individual and group dynamics, and elucidating problems and options, naturally depends on his ability in this field, which is not necessarily one which is the birthright of every psychiatrist and which can - because it is not medical - be assigned to members of other disciplines (in the same way as individuals in distress do not necessarily need medical intervention). Nevertheless, the psychiatrist is the traditional counsel. Without falling into the traditional trap of attributing miraculous powers, it should be recognised that his status and influence on the government is greater than that of others in this field, and whilst no one can escape from his responsibility as citizen and, therefore, from the obligation to address the predicament of the mentally ill, the psychiatrist is in a unique position to humanise, liberalise and socialise services for the mentally ill and those at risk. By acting together and enlisting others of the same conviction, psychiatrists could create the powerful lobby needed to confer on the mentally ill the rights which, by virtue of their human dignity, are theirs: to live in the least restrictive setting, to obtain help in order to enjoy this setting, and to contribute once more to the well-being and wholeness of our society.

REFERENCES

1. E. Jansen, "Politics and Planning" in: The Therapeutic Community, E. Jansen, ed., Croom Helm, London (1980).
2. Report of the Richmond Fellowship Enquiry: Mental Health and the Community, Richmond Fellowship Press, London (1983).
3. Mental Health Act (1959).
4. Government White Paper 'Better Services for the Mentally Ill' (1975).
5. Report of the President's Commission on Mental Health (USA,1978).

POLITICS OF COMMUNITY CARE: A STRATEGY TO COMBINE EFFORTS OF PROFESSIONALS AND A CONSUMER ORGANIZATION

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In its broadest sense, the term politics stands for 'occupying oneself with changes in society'.
In practice, politics are connected with government policy and decision-making. However, the decision-making phase is preceded by an extensive process that can well be influenced.

When professionals in mental health care meet to deliberate community care politics, they actually engage with two aspects of the process preceding governmental decision.
The first is an internal discussion amongst the professionals on the desirability of a change in policy regarding delivery of psychiatric patient care. This concerns the priorities to be adopted in terms of facilities.
The second is to do with a strategy designed to influence government policy in such a manner that the facilities which are assigned the highest priority are realized indeed.

I will gladly enlarge on these two aspects of community care politics in this paper.

DESIRABILITY OF A POLICY CHANGE

In most countries, which includes the Netherlands, the majority of health funds are spent on hospital care. Mental health care expenditure in our country amounts to 3,500 million guilders, 2,900 million going to hospital care, 500 million to community care and only a good 100 million to halfway houses and daycare. This means, when expressed in dollars, that out of every 7 dollars about 6 are spent on hospitals, leaving 1 dollar for community care. Halfway houses, therapeutic communities and other facilities receive a mere twenty-five cents.

In scientific research these past years however there has been a growing awareness that admittance to a mental hospital is less favourable to a patient's possibilities for social development than is his taking residence in one of a series of experimentally tried out alternative facilities. Last year, for instance, experiments with alternatives of this kind were reviewed at length by Brown & Kochansky in the American Journal of Psychiatry, and by Keppler in the American Psychologist. In their conclusions, these authors commented on the curious procedure in most countries continuing to grant priority to 'large-scale mental hospitals'.

Countries such as the United States and the United Kingdom form an exception. There it has been tried to reduce the number of mental hospital beds, which endeavours have in part been successful. However, options like halfway houses (in America and the UK) and well-spread ambulatory treatment (UK) have not received greater attention instead, which is the reason why the decrease in bedding was less effective than had been hoped. Another exception is Italy, where a drastic change in policy on mental hospital care was implemented recently.

One might expect the experiences with both experimental research and the change in policy in the US and the UK to lead to a reduction of large-scale hospitals in favour of smaller facilities and programmes for well-distributed daycare and community care.
Reality tells a different story! It is true, many symposia are dedicated to this theme, but changes are much too slow in materializing and, if at all, are effected on too small a scale.

WHAT IS HOLDING UP PROGRESS IN POLICY CHANGES?

Consensus among professionals is certainly inadequate as yet, especially with respect to defining the most desirable proportion between hospital and community care services.

In my opinion, a major blocking factor is lack of a strategy, sufficiently effective to influence politicians and government policy. To demonstrate how this influence can be exerted, I will tell you about our experience in the Netherlands last winter, when we managed to change the government policy.

ILLUSTRATION

Last year a curious procedure was adopted by the Dutch government. After a legal provision had been instituted regulating the financing of community mental health care, and the government had issued a report on the development of halfway houses and similar facilities, the Minister of Health addressed a letter to Parliament

in May 1982 in which she announced a new construction and reconstruction programme for mental hospitals requiring no less than 570 million guilders (or 120 million pounds sterling). Realization of the plan meant priority for hospital care. However, money can be spent only once and the flow of funds in that direction left no funds for development of alternatives. If we were to prevent this, we had to provide for a strong lobby on short notice to sway politicians and mobilize public opinion.

We decided on a small action group. Apart from two professors, it was also joined by the Chairman of the Consumer's Association, a large organization of psychiatric patients. By writing articles in the daily press, we succeeded in generating the interest of the public. A controversy raged between advocates and opponents, who vehemently attacked one another's viewpoints in the papers, weeklies and trade journals. Meanwhile, the group collected signatures protesting against the Minister's plans. Our call for adhesion met with a great many positive reactions.

We invited a few politicians for a private discourse and in order to advise them as widely and as thoroughly as possible. The articles, finally, were bundled along with an explanatory statement asking for a building-plan freeze. This petition was sent to all Members of Parliament. A few M.P.'s moved a resolution insisting that the Minister should abandon her intentions and change policy in favour of a coherent system of provisions for the small-scale halfway housing and community care sectors. Fortunately, the resolution was carried unanimously.

WHAT WE LEARNED FROM OUR CAMPAIGN

In the first place it taught us that politicians needed instruction. Without it they could not be expected to comprehend the far-reaching consequences of the Minister's building plans, which if not opposed were about to lay down mental health care policy for decades to come.

We also learned that official bodies and politicians have a general inclination to listen to associations of interested parties. Hence, the development of tactics designed to effect a switch in policy, it is important to form a group strong enough to efficiently voice its aims.

We noticed that, at least in the Netherlands, existing groups were particularly organized around such themes as psychiatric hospitals and that they were inclined - starting from the focus of their attention - to maintain these facilities and experience alternatives as being competitive. For the time being, this mode of association means taking a conservative stand, which causes renewals to be implemented at an extremely slow pace.

Our experiences have shown that the way out of such an impasse is in the formation of a group composed of professionals and consumers. In our case this combination of experts in technique and experience represented a forum which captivated the politicians' serious attention.

In the Netherlands, these events have prompted us to form an association of professionals and patient-consumers for the purpose of diligently pursuing qualitative improvement of mental health care.

Summarizing, I think that if politics in community care are to become a success, it is high time:

1) that professionals in psychiatric care reach agreement with their consumers on the most desirable facilities in order to increase the quality of care delivery, and also that they indulge to a lesser degree in the inclination shown by institutional organizations to turn organizational and economic interests into leading principles;

2) to recognize that progress in our scientific knowledge not only points to the detrimental effects of hospitalization as an isolating form of care, but at the same time offers indications for a more optimal social adaptation and development of psychiatric patients if use is made of community care and types of small-scale residence;

3) that professionals, together with consumers - forming one group which is highly interested in proper care delivery - pay more attention to advising politicians, so as to achieve the changes in policy that will result in a better balanced interest in community care side by side with hospital care.

THE PSYCHIATRIST AND THE PRIMARY CARE NETWORK

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I wish to examine the relationship which ordinarily, exists, and the relationship which ideally should exist, between the psychiatrist and the primary care physician. Although the major theme of this paper is the nature of that relationship in the neighborhood health center, in order to illuminate its vicissitudes, I wish to compare and contrast the actuality within the hospital setting with that in the neighborhood health center.

The neighborhood health center and the primary care physician have emerged as important new "care-takers" in medicine, in large part, because of the recognition that with the disappearance of the general practioner and the horse and buggy doctor, an aspect of total patient care and in particular, of listening to the patient, had been lost. The psychiatrist has been asked to assist medicine in recovering the bio-psycho-social perspective of the physician.

In accepting this responsibility, the psychiatrist has clearly undertaken an educational task. In the actual treatment of patients he offers himself as a role model, especially in the crucial area of listening and trying to understand. In the context of participating in clinical conferences, he attempts to display the way in which "listening" can contribute to decisions about patient care and can significantly reduce the chronic use of the clinic or health center. In his participation with the entire staff, particularly surrounding crises in patient behavior, he can demonstrate the significant role that the feelings elicited in physician or nurse by the emotionally disturbed patient, can have in producing strife and tensions within the care-taking group.

In the hospital, the liaison psychiatrist and the primary care

physician share an identical assumption about their work together. The psychiatrist is committed to teaching the primary care physician as much as possible about the diagnosis and treatment and management of the psychological accompaniments of the psychological stimuli of the symptomotology which brings the patient to the clinic. The psychiatrist assumes that he will be helpful in training the primary care physician to undertake an increasingly significant role in the psychological investigation and management of the psychological components of illness. The primary care physician shares this assumption and believes that he will increasingly become the "complete" physician by virtue of the educational aspects of his liaison with the psychiatrist.

Unfortunately, this shared assumption is marred by an unspoken ambivalence on the part of each. For the psychiatrist there is the real reluctance to give up his expert role and to truly turn over his psychological competence to the other physician. For the primary care physician there is a somewhat similar unspoken reluctance to be burdened with the psychological aspects of illness. Compounding this impasse is the fact that it is just those most seriously psychiatrically ill patients, those patients, with chronic psychotic disorders or severe character disturbances that many psychiatrists would prefer not to treat and it is this same group of patients for whom the primary care physician would like to avoid accepting responsibility. The only solution to this dilemma is the solution which has proven itself to be effective in a variety of settings. Before the psychiatrist offers to teach, he must indicate his willingness to take on the actual work with the patients who are seen as a bother, and annoyance or a threat to his colleague.

In the neighborhood health center, in many ways, it is easier for the psychiatrist to negotiate a satisfying and satisfactory position for himself. In the neighborhood health center, the emphasis is upon clinical patient care and not as much on education as it is in a hospital setting. If the psychiatrist assumes a fair share of the burden of clinical care within the health center, the educational activities which he prizes will occur as a viable byproduct of his clinical activity. The staff of the neighborhood health center often understaffed and underpaid, see themselves as being involved in a desperate and heroic attempt to provide service to an underserved population. If the psychiatrist is willing to share in this assumption and definition of their activity, he can become an equal partner.

Whether in the hospital setting or in the "field" of the neighborhood health center, it is useful for the psychiatrist as consultant and as liaison physician, to recognize something of the differences with which he will be percieved and utilized by the different medical disciplines.

In working with the medical internist as the primary care physician the psychiatrist will find himself more easily accepted since the primary care internist already sees himself as giving total care and is therefore not as threatened by an expert "caretaker" who seems to offer more than he, himself, can provide.

In working with the obstetrician, as primary care physician, the psychiatrist must be aware of a somewhat different psychological milieu. The obstetrician who has elected a more specific area of medical practice and yet who places great value and satisfaction upon his experienced relationship with his patients, will often be more competitive with a psychiatrist as a member of a discipline which challenges his own area of extertise and worth. In consequence, it is common to find that a primary care physician whose speciality is obstetrics will often turn to psychologists for help with the mental health needs of their patients, finding in that non-medical discipline, less of a challenge to their own role.

The same situation is true with pediatricians in their role as primary care physicians. Not only, again, have they chosen a more sharply defined area of medical practice than the internist but because of their crucial interest in child development and of the relationship between child and parent as a constant concern in the health or illness of their patients, the personal relationship not only to the children but to the parents, is an important part of their practice satisfaction. Here again, the psychiatrist is seen as a more competative rival, as another physician who may encroach upon their territory - a territory to which they are never fully convinced that they can justifiably claim - unlike the internist. Pediatricians as do obstetricians, often find psychology a more comfortable discipline with which to deal.

Curiously enough it is the surgeon with whom the psychiatrist may often have the most satisifying and useful liaison and consultant role. The surgeon has never laid claim to areas beyond the more "material" aspects of bodily functioning and comfortably leaves concerns with emotions, with fantasies and conflicts to the psychiatric practitioner. It is so clear that the psychiatrist and the surgeon are involved in such different aspects of the human being and by choice can not expect to share the others expertise, that rivalry is not a serious issue between the two.

Anticipating these differences in the relationship both in the hospital and in the neighborhood health center, can provide the psychiatrist with useful guidelines both as to this behavior and also as to the disappointments and failures in his mission which he will inevitably experience.

Finally, I would like to say something about the tensions which exist, not just between the psychiatrist and primary care physician

but between the neighborhood health center and the "parent" hospital. It has seemed to me that it is appropiate that the psychiatrist examine this relationship which often is a source of great distress to both, and that he use his particular understanding of human relationships to diminish some of the tensions. These tensions, it seems to me, derive fundamentally from the way in which the hospital is seen as a demanding and restricting parent by the neighborhood health center to which it has often given "birth" and the way in which the neighborhood health center is seen by the hospital as a rebellious and fractious child who refuses to uphold the standards of his family or to recognize their "gift of life."

In the psychiatrist's movement between the two settings, he can indeed help to clarify some of these issues which provide tension; not by directly addressing them in the parent child modes of which I have spoken but by using this knowledge, he can help each to see the exaggeration of the threat which each preceives and can help find ways for each to give acceptable acknowledgement of their relationship.

Finally, it is a curious fact, which needs to be noted, that it is only the psychiatrist who has defined this unique role for himself as a teacher to the other medical disciplines. Surgeons act as consultants to medicine, medicine to surgery, pediatricians offer medical advice to their obstetrical colleagues. Psychiatric inpatient units may have a internist who functions as a part of their staff, but not as an educator, not in the liaison role. It is psychiatry, alone, that has said "our discipline is a necessary part of every other general or specialized practice of medicine and therefore you must receive not just clinical help but education from us." It is necessary for the psychiatrist to recognize the assumption of superior wisdom which this role may suggest and to walk humbly with his colleagues along the common path of patient care which ultimately means <u>caring for</u> the patient.

COMPARISON OF DIFFERENT AUSTRIAN COMMUNITY MENTAL HEALTH SERVICES

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An attempt shall be made to demonstrate connections between changes in psychiatric hospitals, the development of community mental health services (C.M.H.S.) and primary care in Austria.

In Austria there are 0,74 physicians per 1000 inhabitants. While the number of these physicians has remained unchanged in recent decades, the number of specialists has increased, so that we have now as many specialists as physicians. There are thus an average of 1.48 ambulant practicing medical doctors per 1000 inhabitants.

The difference between urban and rural frequency is considerable, e.g., there are 2.55 doctors per 1000 in Vienna, six times as many as in the rural area of Burgenland (0.4/1000).

Follow-up care of discharged patients as well as the referral to the hospital is mainly effected through the physicians. In recent years, C.M.H.S. have been set up in some areas but not in others, so that the question arises whether the diminuation of psychiatric hospitals depends on these services.

The main part of psychiatric inpatient treatment is performed by ten large hospitals, whereas the much smaller psychiatric university hospitals can be considered as principal diagnostic centers (see Fig.1).

The largest of these about one-hundred year old hospitals have about 9000 beds and a catchment area of about 700,000 inhabitants. The result is naturally a relatively centralized structure, and often the distance to the hospitals amounts to more than 100 kilometers.

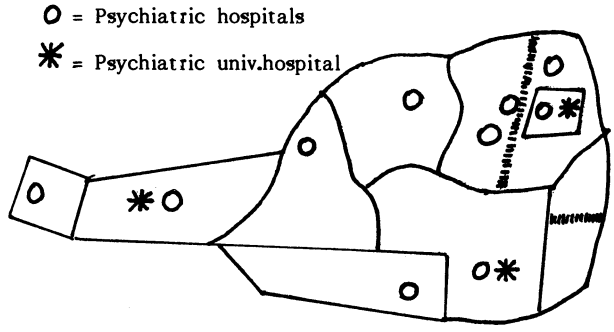
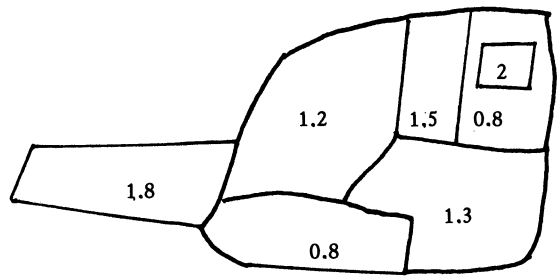


Fig. 1. Locations and catchment areas of the ten largest Austrian pyschiatric hospitals (9000 beds) and of the three university hospitals (500 beds)

In the last 20 years the number of psychiatric hospitals was reduced all over Austria. As has been the case all over the world, the duration of stay has also been reduced. The number of occupied beds per 1000 inhabitants (prevalence) however, varies considerably. Figure 2 shows that we have about two occupied beds per 1000 in Vienna, whereas Carinthia and Lower Austria have only 0.8 beds per 1000. These numbers are not correlated, as I hope to show later, with the numbers of ambulant practicing physicians or with the existence of C.M.H.S.

Different traditions in the development of psychiatry and the different practices of admission and discharge seem to be the most plausible explanations for this difference.

The stationary incidence also varies to a high degree. - In the densely populated city of Vienna for example, the incidence is relatively high, but it is as high in the rural area of Salzburg, where the population density is much lower. In a different rural area- the east of Lower Austria- the incidence of 3 admissions per 1000 inhabitants is relatively small.



Total Prevalence: 1.42/1000 Inh.

Fig. 2. Prevalence in Austria (Laburda 1982)

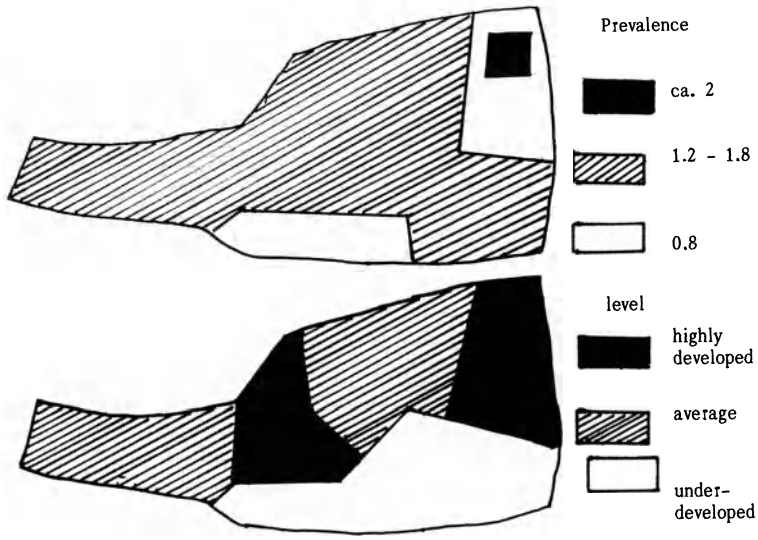


Fig. 3. Comparison between prevalence and levels of social-psychiatric services in Austria

The C.M.H.S. in Austria are, as far as their quantity and quality are concerned, in very different stages of development, so that it seems useful to compare the developmental stage with the stationary prevalence (see Fig.3). In the lower part of that figure we have differentiated zones of a high, average, and low developmental level. In the upper part we see the zones of high, average, and low prevalence. There are areas where a comparatively well developed service (as for example in the east of Lower Austria) lies in a region with low prevalence. More often however, we can find a different relationship. Good services, for example, in Salzburg and Vienna, lie in regions with high prevalences. In Carinthia or in Styria, where we have almost no C.M.H.S., the prevalence is nonetheless low.

Thus, it can be assumed that at least in Austria the creation of C.M.H.S. is not the main reason for the drop in the number of patients in the psychiatric hospitals. Table 1 shows some possible reasons for the diminuation of psychiatric hospitals.

The reduction of the stationary prevalence depends most certainly on changes in the practice of admission and discharge, which are the consequence of an attitude change in the doctors. Reasons for this change are historical changes and the new possibilities of psychopharmacology.

The C.M.H.S. seem to have less influence.

Table 1. Reasons for a Diminuation of Psychiatric Asylums

Changes in the practice of admission and discharge
Means of health policies (finances, etc.)
Historical changes (occupational offers, tolerance)
Psychopharmacology
Development of social-psychiatric services

Table 2. Difficulties Encountered in the Diminuation of Psychiatric Hospitals

Own dynamics of large institutions
Lack of sheltered housing facilities and workshops, etc.
No service duty of the ambulant and semistationary services in standard catchment areas
Rigid professional rules

Finally we demonstrate (see Table 3) that special difficulties arise if you want to reduce the size of a psychiatric hospital. The interests of the personnel working in the hospital sometimes slows down attempts at reform. Lack of sectorization, and therefore no service duty of the ambulant and semi-stationary services, is the reason for the fact that patients discharged from the hospital are not treated, but a different clientele of less seriously ill persons.

In a country like Austria, with the heritage of bureaucracy of the Austro-Hungarian Monarchy, such changes are much more difficult to achieve than in a country with less rigid traditions.

References

1. Danzinger, R., Lyon, G., Tholen, E.: Das Beratungszentrum für psychische und soziale Fragen in Graz. In: Mitteilungen der österreichischen Sanitätsverwaltung 1980 Nr.5, 81-90
2. Danzinger, R., Pakesch, E.: Psychoanalyse und Gemeindepsychiatrie. In: Sonderdrucke aus: Psychoanalyse als Herausforderung, Verband der Wissenschaftlichen Gesellschaften Österreichs, 1980
3. Danzinger, R., and Lyon, G.: Das Beratungszentrum für psychische und soziale Fragen in Graz, Verlag d.Österr.Akademie der Wissenschaften, Wien 1982
4. Dilling, H., Weyerer, S.: Epidemiologie psychischer Störungen und

psychiatrische Versorgung, München 1978
5. Lechner, H., Danzinger, R.: Experiences with a Community Mental Health Center in the Rehabilitation of Psychiatric Patients in Graz.
6. Wing, J.K., Fryers, T.: Psychiatric service in Camberwell and Salford. Statistics from the Camberwell and Salford registers, 1964 - 1974.

TOWARDS COMMUNITY PSYCHIATRIC CARE

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INTRODUCTION

Psychiatric disorders in the community are very common and epidemiological studies have provided convincing evidence that most initial consultations take place in general practice. Studies of this nature in the UK have shown that between one quarter and one third of all illnesses treated by general practitioners are diagnosable as mental disorders (Clare and Shepherd, 1978) and about 15% of the adult population at risk present to their general practitioners with a mental disorder in any one year (Shepherd et al, 1966).

Although general practitioners seem to detect psychiatric problems better nowadays than in the past, the referral rate to a psychiatrist remains highly selective and few of these people are ever referred beyond primary care. Goldberg and Huxley (1980) suggest that 250 out of every 1000 people have some form of psychiatric problem, but of these only 140 are likely to be recognised by the general practitioner as such, and of them only 17 would be referred to a psychiatrist; of the 17 only six would be admitted to hospital. The effectiveness of the psychiatric help provided by primary care agents has started to be questioned and it has been suggested that the psychiatrist should collaborate more effectively with general practitioners to promote community mental health care. Various solutions have been tried such as consultant psychiatrists visiting general practices or psychologists, social workers or health visitors being attached to general practitioners (Brook, 1978; Johnston, 1978).

Although such schemes have offered some advantages where they

have been introduced, the problem remains unsolved because of the large number of mental health professionals which would be needed to staff several locations.

Setting

We would like to describe the development of our model of a community psychiatric centre in Lewisham, SE London. This area comprises a sociologically mixed population of 200,000 people and, although it is situated in an "over-resourced" region, the psychiatric services have been seriously inadequate (Brough and Watson, 1977). There are in-patient beds at Bexley Mental Hospital, 12 miles away, but no psychiatric beds in the district general hospital, no day hospital, and only limited access to hospital out-patient facilities.

In 1976, a small group of professionals came together and developed a limited domiciliary-based project for assessment and treatment. This project created local interest and increasing enthusiasm and was eventually supported by both health service and local authority. Within two years a team was able to move into a vacant suburban house which became known as the Mental Health Advice Centre (MHAC). This Centre serves a catchment area of 82,000 people within the age range 18 - 64 years. It is in a pleasant residential area of the borough, easy to reach by public transport and it looks like an ordinary house with none of the appearance or associations of a hospital psychiatric clinic. There is office space, room for group conferences, interview rooms, a rehabilitation office and a research department.

It started operating in November 1978 and was staffed by a multi-professional team presenting an innovation in community psychiatric care. Today the team consists of psychiatrists, clinical psychologists, community psychiatric nurses, psychotherapists, occupational therapists, community social workers, research workers, volunteers and team manager.

Patients (usually called clients) may be referred by their general practitioners or their community agents, or can simply "walk-in". They do not need to make any appointment and do not need to be referred before visiting the Centre. Intake, however, is restricted to people who live in the catchment area. Some groups, such as children and elderly people, are not accepted for treatment. Similarly, we refer alcoholics or drug addicts to specialist help. But to whoever knocks on the door an attempt is always made to give advice and point him or her in the right direction, even if the person cannot be accepted as a client.

New clients are met by one of the Centre's volunteers and

introduced to the on duty professional. This team member then carries out an initial interview, makes an assessment and contacts the client's general practitioner to seek information and to report the visit.

The whole team then discusses the client at one of the weekly conferences held at the Centre. If it is felt that the person needs more help and treatment, one member is selected as the "keyworker" who then maintains contact with the client, his general practitioner and any other agencies involved, and co-ordinates any treatment programme. Volunteers are also used and work under supervision of the professional key workers on individual and group client treatments. A strong emphasis in treatment is put on the family therapy approach.

It was quickly realised that a number of emergency cases were not able to reach the Centre. A second team was formed with a combination of health service and joint financing funds which has been called the Crisis Intervention Team (CIT). This team consists of a psychiatrist, a senior social worker and a community nurse supervised by the consultant psychiatrist. The CIT responds to calls by general practitioners and goes to problems in people's homes or other places (e.g. police station etc.) Usually emergency referrals request admission to hospital and the initial task of the CIT is to assess the need for admission. Then, if admission is not necessary they arrange for further management accordingly.

Assessment of the Need for and Use of the MHAC

This report is concerned with those clients who came to the MHAC or were seen by the CIT during the first four years e.g. 1979, 1980, 1981 and 1982 and these data are presented for the first time.

The particular questions which we try to answer are:

1. Who are the people using the Centre?

2. What are their problems?

3. From where do they come?

4. How does the Centre operate?

Results

During the four years, 1092 clients attended the Centre and 441 were seen by the CIT. The majority of the clients were females, 64% for the MHAC and 63% for the CIT. The mean age for MHAC clients

was 36.9 years (SD + 13.4) and for CIT 38.6 years (SD + 13.6).

Clients were diagnosed according to the criteria of the 9th edition of the International Classification System (ICD). Adjustment reaction was most frequently diagnosed 34% for the clients attending the MHAC. The more serious psychiatric disorders, schizophrenia and affective psychoses were seen less often (4% and 6%) respectively for the same group of clients. On the contrary, however, schizophrenia accounted for the most frequently given diagnosis for CIT (25%). Most of the clients were referred to the Centre by their own general practitioner, 72% for the MHAC and 85% for the CIT. Thirteen percent of the clients referred themselves to the MHAC, while there was a much less proportion of self referrals seen by the CIT. The most common provided treatment was "counselling" 44% for the MHAC and 37% for the CIT, but 27% of the CIT clients had to be admitted to the local psychiatric hospital comparing with only 3% of those who attended the MHAC.

Discussion

We feel that our results suggest that the Centre and its mode of working is affecting changes in the model of referrals suggested by Goldberg and Huxley (1980). In fact, the second and third filters suggested by these authors, i.e. general practitioners' ability to detect psychiatric disorders among patients and refer them to psychiatric services, may simply be consequences of the present service organisation. This problem might possibly disappear altogether if the service structure was suitably modified.

Certainly the availability of psychiatric care in the catchment area has been improved by the community-oriented programme of the MHAC.

The MHAC has contributed to making services in the catchment area more comprehensive by making available the expertise of a multi-professional team to both general practitioners and their patients. Treatment is encouraged in clients' homes and is more psychological than physical ranging from highly expert individual programmes to relatively non-specific treatments.

There is already evidence suggesting that the MHAC is an innovation in community psychiatry which has served some individuals not previously dealt with by the specialist service, and thus with previously unmet needs. In addition the Centre has allowed a new approach to some patients previously dealt with by the service in a different way.

As the MHAC becomes more established it is being regarded as a significant mental health resource. It is hoped that its effects will extend beyond the health care provided for individuals, to

have an ideological impact on the community, breaking down barriers between ill and well, bringing together health services, social services, and voluntary organisations and furthering education in mental health.

References

Brook, A., 1978, An aspect of community mental health: Consultative work with general practice teams, Health Trends, 10:2.

Brough, D.I., and Watson, J.P., 1977, Psychiatric facilities in an over-resourced NHS region, BMJ, 2:905

Clare, A.W., and Shepherd, M., 1978, Psychiatry and family medicine, in: "Scientific foundations of family medicine", J. Fry, E. Gambrill and R. Smith, eds., Heineman Medical Books, London.

Goldberg, D., and Huxley, P.,1980, "Mental Illness in the Community: The Pathway to Psychiatric Care",Tavistock Publications, London.

Johnston, M.,1978, The work of a clinical psychologist in primary care, J. Roy. Coll.Gen.Pract., 28:661.

Shepherd, M., Brown, A.C., and Kalton, G.W., 1966, "Psychiatric Illness in General Practice",Oxford University Press, London.

EXPERIENCE OF A MOBILE UNIT IN A GREEK RURAL COMMUNITY MENTAL HEALTH CENTRE

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Greek psychiatric services have been characterized till recently by their centralization.Athens and Thessaloniki, the two big cities with a total of approximately 4 million people, out of the country's 10 millions, have been housing 75% of the psychiatric beds.Twenty out of the 52 districts have no psychiatric personnel either in the local city hospitals or the insurance outpatient services.

In planning a new decentralized delivery system for psychiatric services certain principles had to be followed: Availability of services, continuity of care, a broad spectrum of out-patient services, emphasis on the co-operation of the family and community involvement.A geographical sectorization was necessary for such a system to succeed, and administrative, transport facilities etc were first seriously studied.

In Greece such a preliminary work had already been done in the countryside concerning the Primary Health Care(PHC) network. Starting in 1956 Rural Doctors' offices were set up in all major villages, covering two-three neighbouring villages and thus practically the whole countryside. A few years afterwards(1961) the establishment of the Farmers' Insurance Organization and free hospital care, as well as free prescribing and giving of drugs to ambulatory patients(1977) completed the services rendered to the rural population(Kantarakias and Ierodiakonou, 1981;Marketos and Merikas,1981).

A comprehensive CMHC in the countryside

The measures adopted by the PHC services paved the way for other services to be added. We thought that close co-operation with the PHC system would facilitate any plans for a decentralized psychiatric delivery system.

The occasion for an experimental start was given with the creation of a new Medical School in the North-Eastern part of the country, near the Turkish and Bulgarian borders, in 1978. The district of Alexandroupolis has a population of 160.000 and in its capital (30.000 population) the General Hospital housed at the beginning a small in-patient Psychiatric Unit of 16 beds with a 24-hour emergency service and a big Out-patient Clinic providing diagnostic, psychological, psychotherapeutic, consultative and social services for both adults and children.

The multidisciplinary type of the personnel and the variety of services rendered helped in ultimately developing a comprehensive Community Mental Health Centre (CMHC) with an annual turn-over of approximately 300 in-patients and upto 1500 out-patients. In the town of Alexandroupolis, as well as the neighbouring villages, co-operation with the Primary Care, private and hospital doctors was very fruitful; in addition probation Officers, Schoolauthorities, Parents, Welfare Officers, an Anti-narcotic Committee, Church organizations and other local agencies were all involved and helping the cause for mental health.

Nevertheless, it became obvious that most villagers were unable to come in time before their condition was aggravated or attend regularly when needed. In a district where the capital is on the south end of its boundaries, with geographical and trasportation difficulties, the inhabitants of remote villages had to stay in town overnight in order to be examined at the CMHC and many of them insisted on being admitted as in-patients for further examinations, treatment etc. A proper follow-up under such circumstances was impossible.

Experience of the rural Mobile Units

In order to solve the aforementioned problems funds were asked from the Ministry of Health in 1981 for two mental health Mobile Units, the first of such a kind in Greece. These have been staffed by two psy-

chiatrists, one resident in psychiatry, two social workers and partly by the CMHC's psychologist. As originally planned the Units would only function in conjunction with the PHC system.

One Mobile Unit has been visiting twice a week 4 small towns and has been examining patients in the premises of the local HealthCentres belonging to the PHC and the other has been making home visits in smaller villages through the Rural Doctors' network. The places visited were 120-150 kms away from the capital, Alexandroupolis.

During the first 18 months of function the mobile Units, apart from the 4 regularly visited small towns, went to 36 villages. A total of 329 visits were carried out in that period and 2529 interviews with patients took place (2083 in small towns and 446 home interviews in villages).

Regarding sex, women were double in number compared to men. The age of the patients were in 80% above the 40th year of life (25% of the total being above 60).

The twice-a-week services at the 4 Health Centres consisted of diagnostic interviews of new cases, follow-ups of old cases which had been seen either at the CMHC in town or by the Mobile Units, drug prescribing or regulating the maintenance doses, consultation to the family, supportive psychotherapy to the patient, solving of his problems either by guidance or after a brief, here-and-now type of intervention(Ierodiakonou,1983). A psychiatrist was always included in the mental health team of the above services.

The home visits in the villages were mostly made by social workers and included sensitization of the family to the actual problems of the patient, consultative work with various members of the family, emotional support to the patient and a possibility for him to ventilate,social rehabilitation, occupational or pension problems, contact with the rural doctor of the village, the community authorities etc.

Generally speaking it can be said that the nature of the services offered to the community of this particular rural district were in 77% of the cases psychiatric, in 63% social, in 16% referral for consultation by a somatic physician and in only 2.2% admission to a Psychiatric Department(i.e. 1.8 to the open-door Dert of

Alexandroupolis and 0.4 to the closed-door State Hospital).

Diagnostically the basic psychiatric conditions of the patients, both of those referred to the four Health Centres and of those been visited in the villages at their homes had as follows:

Neurosis & Psychosom.	54.4%	Ment. retardation	1.3%
Functional Psychoses	13.8%	Alcoholism	1.6%
Involutional syndromes	5.3%	Neurolog.diseases	14.0%
Organic Psychoses	5.8%	Diseases of other specialties	3·8%

There were some striking differences between the diagnostic groups which were judged by the Mobile Unit personnel as in need of mental health care and those referred by others.Younger people,for whom preventive measures could be more effective,were chosen by the Mobile Unit to be visited, as well as ambulatory psychotics whose maintenance drug treatment should be continued. In fact follow-up numbers were double in the group of home visits compared to those referred by other agencies. The diagnostic group of the latter included, among others, at the beginning a great number of neurological cases because of the confusion about the actual role of a "nerve-doctor".

Referrals during the first months of the Mobile Units' function were made mainly by the PHC network (upto 71.2%), while after 18 months self-referrals and referrals by ex-patients increased to a great extent (reaching upto 66.1%), showing that the public has been successfully informed about the services of the Mobile Units and that rural people started using them without prejudice about the psychiatric "stigma".

The following table showing the decrease of patients from the northern areas reaching the district's Hospital in the city of Alexandroupolis(to the south) proves that a great number of the population in those areas could be taken care of near their homes by the Mobile Units, with all beneficial effects regarding time, expenses, primary and secondary prevention etc.

CITY GENERAL HOSPITAL
OUTPT DEPT.-PSYCHIATRIC CASES

	1980	1982	
From all over the district	952	1142	
From the northern areas	332	290	
	:34.9%	:25.4%	p (0.01

Collaboration with the PHC network

In the district of Alexandroupolis PHC is mainly served by 35 Rural Doctors covering all villages in the area and the four health centres in small towns, During the period studied, i.e 18 months, more than three quarters of them were involved in the Mobile Units' tasks. These doctors are a kind of emergency medical force, being on duty for 24 hours and most of them staying in the village for a minimum of one year,- a compulsory assignment after graduation.

The rural doctors were given information about the Mobile Units' aims and about some common psychological conditions and their handling at a seminar, a couple of months after starting the visits to the countryside. Unfortunately because of the temporary appointment of the rural doctors, the members of the Units had to get in touch with the new doctors in many villages after a few months.

On the whole collaboration with the young rural doctors proved more than successful. Feeling that they are lacking proper psychiatric training, they accepted the mental health officers' initiative with enthusiasm and relief in difficult cases, they served as liaison between the capital's CMHC and the patient, they followed the patient in the absence of the Mobile Unit and reported by phone on the development of his condition. The fact that they could dispense free drugs proved very helpful for follow-up patients.

It is understandable that such a close collaboration gives the PHC officer a sense of security and he himself, after a while, acts in a consultative and supportive way; in many instances he tries to solve family crises and can identify cases early enough. Though the time he lives in the village is usually restricted to one year, he gets acquainted with local authorities and social agencies through which he can help psychiatric patients in rehabilitation, occupation etc.

Conclusions and proposals.

The experience of one and a half years of work by Mobile Units within the services of a comprehensive CMHC in the countryside has been very encouraging. Continuity of care and availability of services have been achieved by providing mental health personnel twice a week in the Health Centres (belonging to PHC) of small towns and also

for home visits in the villages. Collaboration with the PHC Rural Doctors has been extremely useful, both because they acted as the link between the CMHC and the patient and because there was a continuous referral between them and the Mobile Units.

It became evident that any CMHC organizational plans for rural areas must be in close co-operation with the PHC officers, who should increasingly undertake part of the patient's handling themselves. CMHCs cannot depend on their own personnel only if they are going to offer comprehensive services to the total population of a defined catchment area and must gradually hand over to the PHC the follow-up of chronic and psychosocial cases, as well as prevention in episodic and transient crises. The PHC physician should, nevertheless, feel free to refer to in-patient or other CMHC services as soon as he encounters difficulties beyond his medical capabilities.

Psychiatric epidemiological studies with easily applied methods (Iacovides et al.,1981) will eventually delineate better the primary physician's possibilities in helping a CMHC's task, since he is the one more close to the patient and the family, and he more than anyone else can provide sufficient time and constant support to them.-

REFERENCES

Iacovides,A.,Ierodiakonou,C.S.,Bikos,K. and Kantarakias, S.,1981, Prevention of Psychiatric Disturbances following Gynaecologic operations, in:"Aspects of Preventive Psychiatry", G.Christodoulou,ed., Karger, Basel.

Ierodiakonou,C.S.,1983, Psychotherapeutic possibilities in a rural Community Mental Health Centre, Am.J. Psychotherapy (in press)

Kantarakias,S. and Ierodiakonou,C.S.,1981, Psychiatric services in Greece: a new Community-oriented policy, VIII World Congress of Social Psychiatry,Zagreb

Marketos,S. and Merikas,G.,1981, Primary Health Care in Greece, World Health Forum, 2:69

PRIMARY CARE AND MENTAL HEALTH SERVICES IN THE SUDAN

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ABSTRACT

Sudan has already gone some decades ahead in implementing primary health care before WHO proposed a new approach to promote health services.

Dispensaries, dressing stations and mobile health units were set up all over the country to meet the urgent health needs of rural and nomadic communities. Primary Health Care figures the third in the priority scale in our National Health Programme 1977/78 - 1983/84. There is evidence from practice and annual reports that primary care programme is progressing satisfactorily. Yet, there is no explicit mentioning of incorporating mental health within the programme. Mental health policy had not been reviewed; it focuses on establishing psychiatric units in general hospitals with out-patient services. To date, these units have not exceeded seven in a country one million square miles with a population over twenty millions.

The results of a strudy, coordinated by WHO, on the extension of mental health care, in which Sudan collaborated with six developing countries, showed that the existing health staff are capable of acquiring skills and applying them to provide basic mental health care. The amount of additional resources required to meet this are limited and justified. The study pointed out that the outstanding problems are of political, administrative and managerial kind.

In a recent conference on traditional medicine organized by WHO in Khartoum the possible integration of some indigenous healers within the national health services was examined. It was clear that some faith healers in the Sudan are qualified for that end.

Key Words

Primary health - Mental disorders- Faith healers - Key Informants - rural community.

INTRODUCTION:

Sudan is the largest country in Africa with an area of about one million square miles. The population is estimated at about 18 - 20 million inhabitants; About 71% reside in rural areas, 18% are urban dwellers whereas 11% are nomadic. Khartoum is the most urbanized province with nearly 75% of its population living in urban areas.

The Sudanese are of different ethnic, cultural and socio economic background. Colloqual Arabic is the language of communication though most tribal divisions speak their own local diallect. The majority are of Islamic faith. There are also few Christians and pagan - animists.

A large proportion of Sudanese people still believe in demons, evil spirits. evil eye, black magic, witchcraft and other supernatural forces as cause of mental illness. A considerable prejudice against mentalillness exists; and social stigma is strongly attached to mental disorders. Therefore, in rural areas a help for a person with a mental problem is first sought secretly from an indigenous practioner who is usually a faith or a religious healer or a "Zar" spirit exorcist or "Kujur" therapist. All this depending on the ethnocultural background of the patient.

The neuropsychiatric disorders prevalent in the Sudan do not differ from those seen in other parts of the World, but as in other developing countries, toxic factors, nutritional difficiencies and infections play major role in the relative increase of acute organic psychosyndromes. Schizophrenic, manic depressive psychosis and anxiety state and epilepsy are the major causes of psychiatric morbidity in our practice. Hysteria with gross conversion symptoms in young women is commonly seen. Alcohlism is causing a lot of concern in many urban communities functioning under conditions of rapid socio-economic change. Low prices and easy availability of native wines "marisa" and spirits "Aragi" aggravating the situation. Dependence on opiates is virtually non-existent in the Sudan. Amphetamines,

LSD are unknown. Cannabis "Bango" is smoked in various parts of the country. It features as a major problem in connection with dependence. This is inferred from psychiatric clinic records and police seizures of illicit hashish. A common clinical presentation of hashish intoxication is a schizophreni- from psychosis with marked perplexity in a young man who is most probably a student.

There are no official statistics on the incidence or prevelence of mental disorders in the Sudan. However, systematic surveys of psychiatric morbidity in total populations carried out in Taiwan (Lin 1953), Nigeria (Leighton et al 1963), and India (Dube 1970) have shown that the incidence of psychosis, severe subnormality and epilepsy among populations is comparable to that found in the developed countries in Europe and America. Using the widely accepted estimate of one percent, as the prevelance of seriously disabiling mental disorders in all human communities, the Sudanese people affected by mental health problems to be 180,000. When we consider relatively less disabling mental disorders such as minor neurosis and psychomastic conditions the figure will be inflated ten fold 1,800,000.

Modern mental health care started in the late fourties with efforts of the late Prof. Tigani El Mahi who established the first psychiatric out-patient clinic. But the planning of psychiatric services did not keep pace with the general health programming of the country because of low priority accorded to mental health, lack of information about the burden of mental health problems on the community and the scarcity of financial resources combined with pressing needs to combat endemic and inter-current diseases of general health.

The mental health resources are very meagre at the present. There is one psychiatrist per million of population and one psychiatric bed for 72,000. We have only one psychiatric hospital with a capacity of 150 beds. The total number of psychiatric units in general hospitals are 7 only. Only few of these units have in-patients places and some have no spaces for out-patients service. It is evident that with the present facilities, it is impossible to provide mental health care to the whole country. There is strong need to extend psychiatric care to rural and nomadic communities.

Sudan is one of the member states of WHO committed to primary health care which figures third in the priority scale in the National Health Programme 1977/78 - 1983/84. There is evidence that implementation of PHC was quite smooth because the country had adopted a similar policy to extend general health care to rural communities several years before WHO proposed the new approach. The basic units of primary health care delivery is

dressing station which existed long ago. The estimated number of units for the total coverage of the rural community by 1984 is 1247 units. Some provinces have already reached the objectives set for 1984. There is adequate number of qualified primary health workers to deliver health care. Drugs supplies, equipments and buildings were made available partly by government funds and partly from self-help group. Yet, there is no explicit mentioning of mental health within the programme; This is not surprising because mental health policy has not been reviewed; it focuses itself of establishing psychiatric inpatient units within general hospitals. To date only seven such units were set up in urbanized areas; two regions: the Southern, and Western are devoid of any form of mental health service.

Based on WHO's commitment to primary health care and the new orientation of the WHO mental programme a multicentre collaborative study was launched to evaluate the feasibility and effectiveness of community - based mental health care.

In 1976 Sudan participated in the WHO Collaborative Study * on Strategies for Extending Mental Health Care which grew out of the recommendation of a WHO Expert Committee to the effect that the detection and management of priority mental discorders should form part of the regular tasks of a primary health workers. Shagara-Jebel - Awlaia is the study area in the Sudan. It has a population of 59,000. It is 20 - 50 km. south of Khartoum between the White and the Blue Nile. The area had primary health care facilities in the form of dressing stations, dispensaries and health centres; but no mental health services. The study was designed firstly to develop methods required for priority selection, task definition and training; secondly, to determine the feasibility of Committee's recommendations concerning basic mental health care; and thirdly, to evaluate the effectiveness of such care.

In coordination with local health authorities and local community leaders, a series of baseline data were collected by means of (i) Community survey to assess preceptions and attitudes concerning mental disorders and to find cases of serious mental disorders such as psychosis, epilepsy and severe mental subnormality in the community; (ii) an assessment of disability and family problems arising from mental disorders; (iii) the screening of adult and children attending primary health facilities to detect mental disorders; (iv) an assessment of the attitude and knowledge of local health workers concerning mental health Structured interviews and questionnaires were used in community surveys. Case finding was based on responses to seven mental disorders presented to the key informants through

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* See Page (8) Note.

vignette descriptions. Cases of epilepsy and psychosis were regularly found at the rate of 5-10 per 1,000 population. It was striking that patients were readily brought forward by local people once they realize that treatment will be locally available. Patients and their families have been eqger to start and continue treatment. Another feature was that key informants approached have been able to name three or four persons suffering from mental disorder over twice as many as the blind and physically handicapped people known to them. Major mental disorders were readily regarded as serious and socially disabling and help is usually sought from traditional healers because of lack of recognition that effective modern treatment was available.

The frequency of psychiatric disorders among the primary health facility attenders was found to be 10.5 - 17.7% for adults and 11 - 29% for children. Most patients showed neurotic disorders whereas conduct disorders and mental retardation were seen commonly in children. The primary health worker recognized one third as suffering from psychiatric problems. It can be stated that the existing primary health facilities attract a large number of patients suffering from neurotic disorders. Epileptic and psychotic patients remain disabled within the community.

Certain priorities were selected to be seen at primary care facilities. These are the:

i) Psychiatric emergencies- mainly acute schizophernia, mania, drug or alcohol withdrawal states, suicide attempts and acute organic psych.

ii) Epilepsy - Grand mal idiopathic type.

iii) Chronic psychosis - schizophrenia.

The essential tasks for effective management should then be defined in order to avoid over loading and unrealistic expectations from the primary health worker. These tasks were:

i) Recognition of psychiatric emergency.

ii) Containment: patient to be brought to place safely, humanely treated, not to be provoked or abused.

iii) Control of acute excitement using a phenothiazine drug.

iv) Observation + look for possible organic cause.

v) Family contact = consult family, give advice, regular contact of family with patient.

Tasks (i) and (ii) can be assigned to community members, traditional healers, policemen and teachers.

Training of primary care personnel is mandatory. As for community leaders, policemen, teachers and religious healers a short series of seminars on mental health education can be planned. For health workers, training can take place stepwise as follows:

i) A short in-service training course of existing health workers. A two to three hours session held weekly. The contents of the courses are lectures, discussions and practical experience with psychiatric and epileptic patients - constraints:

a) transport difficulties
b) instability of primary health workers due to frequent transfers from one health facility to another.

ii) The design of mental health component in the basic training of primary health worker.

iii) Further supervision and refresher courses. The methods and material used in the training of auxiliary health workers in mental health.

Provision of Drugs

Psychtropic drugs found to be essential for primary mental health care were: chlorpromazine, Amitriptyline, diazepam and phenobarbitone. These drugs can be safely used by non specialist staff and that a high proportion of all patients needing paychotropic medication can be treated with these drugs. The drugs to be handled by the most simply trained staff are phenobarbitone and chlorpromazine tablets. These are used for mainenance theapy of epilepsy and chronic psychosis at low cost of 6 US cents and US $1-20 respectively.

In Shagara Jebel Awlaia one of the important ways to make communities to participate in the impementation, adoption orientation to mental health care was visits by research team members to the villages of the area, talking to community leaders and by making direct contact with patients and their relatives.

This will lead to policy review affecting primary health care, excisting mental health services training programmes and resource allocations. Incorporation of mental health in primary health care will be taken more seriously.

In a recent intercountry conference on traditional medicine

organized by WHO in Khartoum the possibility of integration of some indigenous practioners within the national health services of the countries of the Eastern Mediterranean region was examined. It was clear that some faith healers in the Sudan are capable of providing basic mental health care.

Conclusion

The evaluative results of the WHO Collaborative Study show that effective set of interventions for defined priority mental disorders can be devised within regorous resource limits. Observeable changes in the knowledge and attitude of health workers can occur, individuals suffering from disabiling mental disorders have been reached and provided with effective treatment in significant numbers. Appreciable shifts in community reactions to mental disorders have also occurred.

The out-come of the study provides a substantial basis for planning future community mental health which did not feature in the National Health Plans primary health care programme in the Sudan. The detailed material from the intervention phase (e.g. training material, case register techniques, list of essential drugs, reporting systems, methods of on going evaluation) is available for further use. The existing health staff are capable of acquiring mental health knowledge and skills and applying them to provide basic mental health care. The amount of additional resources required to do this are limited and are fully justified by the improvement in health status of the population. The outstanding obstacles are of political, administrative and managerial kind. What has been achieved on a small or medium scale, must now be applied nation-wide.

References

Baasher, T.A. et al (1979) Rural Psychiatry: The Fayoum Experiment Egypt Journal of Psychiatry. ,2, 77 - 87

Climent, C.E. et al (1980) Mental Health in Primary Health Care, WHO Chronicle. 34: 231-236

Harding, T.W. et al (1982) Community Mental Health Care in Developing Countries: submitted for publication in the American Journal of public health.

National Health Programme: The Democratic Republic of the Sudan, Khartoum. April 1975.

Primary Health Care Programme: The Democratic Republic of the Sudan. Khartoum. May 1976.

Wiq, N.N., et al (1980= Community Reactions to Mental Discorders Key Informant Study in Three Developing Countries Acta Psychiat. Scand (1980) 61,111 - 126.

* Note: The WHO Collaborative Study on Strategies for Extending Mental Health Care was carried out in seven geographically defined areas in Brazil, Colombia, Egypt, India, Philippines, Senegal and Sudan and is designed to develop and evaluate alternative and low cost methods of mental health care (including training methods) in developing countries.

CURRENT DEVELOPMENTS IN HOSPITAL AND COMMUNITY SERVICES FOR THE MENTALLY ILL

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INTRODUCTION

The problems dealt with in this paper are common to developed and to developing countries. The needs for various kinds of treatment and care of people who become severely and/or chronically mentally ill are much the same in all parts of the world. How the needs are met will, of course, vary according to tradition, culture and local resources; the same principles can be applied in many different ways. No one ideal pattern of psychiatric services can be recommended for use everywhere.

THE PROBLEMS PRESENT BY MENTAL DISORDERS

The essence of the matter is that psychiatric, like other, services tend to be established and maintained for a variety of reasons, not all of which have to do with the relief of the problems presented by people with mental disorders. The central problems take the form of personal suffering due to painful psychological experiences, limitation of activities and achievements due to psycho-biological disabilities, and distress or damage caused to others because of the disturbed behaviour of the afflicted person. These central problems are often amplified by social disadvantages such as poverty, lack of education or work opportunities, stigma or lack of understanding, absence of social support and inadequate facilities for care. These two sets of factors, in turn, affect the individual's self-esteem and self-confidence and may lead to a low expectation of the quality of life he or she can achieve. This may be realistic if help is not

forthcoming but may be an obstacle to progress if it is.

The more that is known about the nature, frequency and causes of the central problems the more rationally can clinicians prescribe forms of help that are effective, acceptable and economic. Knowledge about the epidemiology, course and response to medication of schizophrenia, for example, is now substantial. Just as important, there is now accumulating a body of knowledge about certain environmental factors that, in some cases, precipitate or prevent an acute attack and others that, in some cases, increase or diminish the negative impairments. The role of institutionalism in promoting dependence (not only, incidentally, in hospitals, but in the alternatives to hospitals as well) is now better understood. The extent to which the need for medication is affected by what is happening in the afflicted person's 'social space' is becoming clearer.

Such information makes it easier to plan and adjust a long-term programme of help for someone disabled by chronic schizophrenia. If, for example, there are factors in the family environment that are likely to lead to relapse, a decrease in the amount of contact with that environment may be as effective in lowering the degree of risk as increasing the amount of medication. Decreasing the amount of contact can be achieved in many ways, depending on what is most appropriate in the area concerned.

Of course, schizophrenia is only one of many conditions about which knowledge is slowly accumulating and many of the problems presented to psychiatrists remain mysterious. The point I want to emphasize by using these rather elementary illustrations is that one should always approach a topic such as the theme of this meeting by considering, first, the nature of the problems presented by a particular clientele and, second, the forms of help that are most likely to relieve those problems. Services only exist to 'deliver' those forms of help; to facilitate primary, secondary and tertiary forms of prevention, to minimise suffering,disability and disturbance, and to foster a decent quality of life. Services are not particularly interesting in themselves. They were not created for staff or administrators or social historians.

PRIMARY MEDICAL CARE

In-patient and out-patient care, at least as these terms are understood in the United Kingdom, constitute only part of the psychiatric services. They are not appropriate for the very substantial proportion of the general population who suffer from 'minor neuroses' or 'mental ill-health', most of whom are treated at the primary care level. General practitioners are also responsible for referring people with more severe conditions to the specialist services. One of the interesting developments of

recent years, however. has been a tentative overlap between the two roles, by giving general practitioners more responsibility within the hospital service, by providing psychiatric consultation in primary care health centres, by attaching psychologists, nurses and social workers to general practices, and by involving family doctors in crisis intervention schemes.

These developments are particularly evident in the more affluent areas, perhaps because they attract the best doctors. However, if it means that specialists are starting to become more responsible for the less severe forms of disorder, as happens in some countries where there is no separate primary care system, it could affect the priority accorded to severe illness. It need not have this implication. Three-quarters of patients discharged from hospital after treatment for schizophrenia, for example, go to see their general practitioner during the following year. Both patients and relatives value the services of a good family doctor above all else. The scope for cooperation between primary and specialist levels, in order to improve the service overall, is therefore great.

CHANGES IN IN-PATIENT CARE

However, the most striking changes in recent years, throughout the developed world, have occurred in the hospital services. When the first small asylums were set up during the early part of the nineteenth century, there was a more or less coherent philosophy of gentle re-education towards conformity with a generally accepted code of social behaviour that came to be known as 'moral treatment'. We feel some distaste, nowadays, for the paternalistic values implied, and, of course, many asylums were far from being 'therapeutic communities'. Nevertheless, the contrast with the alternatives in workhouses, 'single care' and destitution was tremendous and it is sometimes forgotten that discharge rates were as high as they are today.

It has still not been fully explained why this early promise was not fulfilled and why the pendulum, which had swung, under the influence of the reformers, away from community neglect, moved past the point of balance towards the other extreme, institutional custody. It was not until the 1930s that it began to swing back, gathering impetus during a new wave of reform after the second world war. It was in 1961 that one of our own government ministers spoke of bulldozing the mental hospitals.

This idea, that large and remote hospitals could be closed and people afflicted with severe mental illnesses could be treated and cared for in other ways, has had tremendous impact everywhere in the developed world. It began with new programmes of social rehabilitation in the hospitals themselves and in the forging of new

links between hospital and community. The concepts were not unlike those of moral treatment, more than a century earlier. The discovery of the new medications demonstrated that these ideas could be applied even in the most old-fashioned and custodial hospitals. Although the movement has been more rapid in some States of the USA and in Italy, and more cautious in the Scandinavian countries, Germany and the United Kingdom, and although countries like Finland still have very high bed numbers, the underlying idea has been extremely powerful.

Of course, it has sometimes been taken to unrealistic extremes. Protagonists have seemed to argue that the problems would disappear with the hospitals. The anti-psychiatry campaign claimed much of the credit for a movement that began in the hospitals themselves, although, of course, it was already 'in the air' waiting to be exploited. But now we can take a more sober look at the consequences and at the implications for the future.

In the U.K., where the numbers of people in psychiatric hospitals are less than half what they were at their peak in 1954, an overwhelming proportion (86%) of the money supporting the statutory care of the mentally ill is still devoted to hospital services. Most people in hospital are still 'long-stay'. It is less easy now than in Victorian times to match the enormous resources then put into building the large hospitals in order to provide a new pattern of 'community care'.

THE MEANING OF COMMUNITY CARE

The term'community care' promises much but the reality is often bleak. Inner city areas are notoriously deficient in social supports, although this is where many people with mental disablement accumulate. The residents of more affluent suburbs may be pre-occupied with material standards that demand a conventional normality. Even supposedly socially integrated rural villages may fall short of romantic expectation. Neighbours do not always help or even sympathise with the problems of the family containing a mentally ill member next door.

Indeed, formal systems of service delivery developed "because the informal networks of mutual aid in local communities were manifestly incapable of meeting the kinds of personal need which arise in complex industrial societies". Some rural communities where the extended family is the norm may perhaps offer an exception, but the pace of development may well overtake them as well. Simply relying on closing large and remote hospitals will not achieve decent community care. The responsibility will simply be transferred to the families and personal supporters of the mentally ill, who will not be able to cope. Three principles must be fulfilled first.

District responsibility

There must be identifiable responsibility for providing services within a defined geographical area. This can take many forms but it must include mechanisms for recognising which people within each District have substantial needs for care and for arranging the most appropriate form of service 'delivery'.

Comprehensive coverage

Services must be flexible enough to cater for a wide variety of needs. A smoothly functioning emergency service is one of the key elements in provision. Crisis intervention, particularly when based on knowledge about people and families likely to be at risk and not solely geared to responding after crises have occurred, can fill in many of the gaps left by inadequate provision elsewhere.

Treatment services should be based in a wide variety of community centres (including day hospitals and hostels), not only in hospital wards.

A range of day and residential units is required, providing for those whose needs are for shelter and security at one end of the scale to those at the other end, whose main need is for help to participate in social activities outside working hours and at week-ends. The broader the range of facilities the more it is possible to concentrate on preventive measures and to pay due attention to the quality of life of the people involved.

The fact that 'new' long-stay patients are still accumulating in mental hospitals suggests that experiment is needed in creating forms of sheltered community that will not perpetuate institutionalism but can be more closely linked to the general life of the community.

Counselling and advice concerning how to live with chronic disability is now regarded as an essential part of a service for people with physical ill-health or disability but we have not yet realised how important this function is for people with mental disablement. Out-patient clinics, welfare agencies and domiciliary visiting schemes should regard this as one of their most important functions. Advice on welfare provisions is an integral part of such a service. The functions of community psychiatric nurses and social workers now overlap considerably but, between the two, there is the nucleus of a system in every district.

Integration and continuity of care

If the functions formerly carried out by large hospitals are to be devolved to a range of smaller centres, some hospital-based, others not, there is an over-riding need for coordination between the

scattered elements of the service. It is very easy for each isolated unit to develop its own admission, treatment and discharge politicies without consultation with the others or relevance to an overall policy for the District. A mechanism for uniting the efforts of all levels of the service - individual care coordinators, multi-disciplinary teams, hospital and non-hospital residential and day units, advice centres, voluntary organisations, and management committees - is needed in every District.

Evaluation and monitoring

Many countries have methods for monitoring health and social services but these are often ineffective. Evaluative research is now beginning to be taken seriously in some countries. This, together with an Inspectorate monitoring publicly stated standards of care, can contribute to an overall improvement in standards without necessarily entailing a large increase in expenditure.

IMPLICATIONS FOR PSYCHIATRIC SERVICES

Whether a country is diversifying its mental health services away from a model based on large and often remote hospitals, or whether it is building up its services from scratch, the same simple principles apply. Both in developed and in developing countries there is an opportunity to learn from the experience of the past quarter of a century in order to move towards a service that is responsible, comprehensive and integrated. Obviously, more progress can be made in some countries than in others, but if we fail, overall, to take this opportunity we shall be left with one policy (that of large institutions) discredited but the only alternative (comprehensive community care) unachieved. Patients and their families will be the ones to suffer. There is surely no question but that all psychiatrists should be promoting the principles of good community care for those with severe and chronic mental disorders or that this is the group that deserves highest priority.

NEW TRENDS IN INPATIENT AND OUTPATIENT CARE IN EUROPE

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INTRODUCTION

The remit of this paper is to describe briefly an international study, methodology and experience with the monitoring and evaluation of new trends in inpatient and outpatient care.

At the beginning of the 1970s, the World Health Organization (WHO), as the United Nations agency with commitment to international health affairs, and, in particular, the facilitation of the exchange of information, embarked on a major study of mental health services in Europe. This study, conducted by the late Dr A.R. May, brought together a wealth of material on the classification of mental health service activities and resources in Europe. It was an attempt to capture, in measured terms, the international perspective of developments in hospital and community services in the Member States in Europe, described in detail in the preceding paper by Dr J. Wing. This valuable experience was published by WHO in 1976. However it was evident that there were large gaps in the information available from national sources, usually the ministries of health. The gaps were largely in those areas of alternatives to inpatient care.

There has been, of course, in Europe a tradition of well established accounting of inpatients in many countries over a century or more. Also, the information systems then available at the beginning of the '70s tended to deal with episodes and not with patients themselves and their unique experience within the systems, which have become much more comprehensive and at the same time more complex in their organization. In a phrase, the dynamic of the patient's experience was missing.

The Study of Mental Health Services in Pilot Study Areas

In order to assist Member States in improving the information systems for planning, development, monitoring and evaluating their mental health services, a study was begun in 1973 of mental health services in pilot study areas. It was believed that more detailed information could be collected more effectively, permitting more intensive study of conditions and services, in a locality within a country.

The project was established in 21 pilot study areas in 16 countries. The areas selected varied widely in size and number of population, the demography, the socioeconomic characteristics, and a survey provided the required information on these and included an inventory of the mental health resources. The study, which was concerned chiefly with the organization and evaluation of mental health services, has had a significant secondary outcome which has been the extension to many areas of the methodology of case registers based on medical recording and data collection systems.

The preparatory work was carried out initially in 11 areas in two phases. Phase one from 1974 to 1976 covered the preparation of the patient information, the collection of data, and an important event of this time was a prevalence count of patients in treatment - a census of patients.

Phase two from 1976 to 1978, included the study of two small cohorts and their follow-up over a period of one year; a cohort of inpatients and a cohort of outpatients, both identified on admission to the services. Concurrently, in phase two, some teams undertook additional studies such as a 'team activity study' and studies on 'cost analyses'.

The results of these two phases are condensed and summarized very briefly. There were tremendous differences in the proportion of patients in the different areas, particularly the inpatients, who had had previous psychiatric contact before entry to the cohorts. The variation was from 4% to 72% among the inpatients, and from 2% to 34% among those admitted to the outpatient services. Significant also, were the wide differences among areas of the sources of referral and the agencies of referral to the service. But, generally speaking, most of the diagnostic categories identified, showed that it was neuroses and personality problems in the outpatient services, while inpatients were predominantly psychotic or organic cases and this held good for all areas. Those areas with a high proportion of elderly, showed the expected increase in mortality rates. Some areas discharged a high proportion of patients after first contact, while others, commonly those with ambulatory alternatives to inpatient care, retained the patients but transferred them within the elements or the components of the comprehensive service. The majority of

inpatients in all areas had left hospital within three months, and very few outpatients were admitted later in that year as inpatients. In some areas, and especially those with an older population, a significant proportion of patients stayed in hospital care continuously throughout the year.

The following variables were identified as indicators of service need and service use: a high population density and high percentages of the very young or the very elderly in the population. Critical too for purposes of evaluation, were the numbers and types; the categories of mental health staff. Patient admission rates, prevalence rates of different categories of patient and the length of stay, were all needed in order to strengthen the planning and evaluation process.

In phase three, 1979 to 1983, the cohort studies and the descriptions have been extended to the 21 areas in 16 countries (see Fig. I). The cohorts of this phase are composed of no less than 200 consecutive patients, who had no contact with the services during the previous six months and who were aged 15 years and over on entry. The data were collected on admission to the service, and the patients were followed up within the service for a minimum of one year and in most areas for two years. In these larger cohorts which were studied over a two-year period, the percentage of patients, for example, with a diagnosis of psychosis varied from 15% to 62% of the total and for those patients again with a diagnosis of psychosis the number of outpatient contacts during the two years varied in the services from 2.6% to 35.4%. When the total of all service contacts is calculated, the total number of contacts per case of psychosis ranged from 24 to 180, and of these contacts, inpatient experience varied from 3% to 25% of the time involved - that is the one or two year period.

CONCLUSION

These wide variations then, in the use of services, especially ambulatory care, are being studied further in each area and analysed against the background of the detailed information and knowledge of the services and the resources provided and the patterns of organization. The conclusions of the study will be presented at an international conference to be held in Europe early in 1984, and will be published by the World Health Organization.

This study of methods of information gathering on patterns of service and their use, has been conducted fairly successfully at a local, or micro-level, and a complex analysis is being achieved. But at the macro-level, that is at the national level, a repeat of the 1972 experience of information gathering on national mental health data has already shown that large gaps still exist in national data collection on mental health services in many countries in Europe. This is particularly so with regard to outpatient, daypatient, and the other ambulatory and alternative services to inpatient care.

It does appear therefore that a major international commitment to definition and methodology for data collection on mental health services for cross-national collaborative and comparative studies remains an urgent necessity if we are to improve the evaluation and planning of this complex of networks of service available today in most of our countries.

The author wishes to thank the Programme Committee of the Congress for this opportunity to present the researches of the many workers in the pilot study areas, to thank them on behalf of the Organization for the large amount of work and commitment to this project over many years.

FIGURE I : Mental Health Pilot Study Areas

ASPECTS OF IN- AND OUT-PATIENT CARE IN ECONOMICALLY UNDERPRIVILEGED COUNTRIES

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INTRODUCTION

The economic, social, and political situation of underprivileged countries reflects on the medical care and on the educational process of their people. Therefore, when we speak about psychiatric care among the underprivileged, we will find certain elements peculiar to each culture and others which are common to underprivileged people everywhere. Naturally, the uneven distribution of income, social injustice, and great misery existing side by side with opulent wealth in these societies will have repercussions in psychiatric care. In these countries psychiatry is not a priority. More care is given to the undernourished and those suffering from infecto-contagious illness and tropical diseases.

Among the poor, the body is the only element left as reference of their existence. Therefore, it is natural that the sufferings directly related to the body get more attention than those related to behavior. It would be difficult to speak about all specific aspects of all the problems that are the starting point of psychiatric care among economically underprivileged people. However, we can choose one country as an example, and see how these problems are taken care of.

I will choose Brazil, my own country, as a model. Despite the fact that it is called a developing country, Brazil has a big foreign debt of around 100 billion dollars, and a process of income distribution that is extremely uneven, resulting in great descrepancies from the social, cultural, and economic point of view. For these reasons, despite the fact that Brazil is a country with a great potential, we

can consider it, from the economic point of view, underprivileged.

We have seen, not only among us, but throughout the world, a great increase in the rate of mental illness. In the last 30 years, the population of Brazil has risen from 52 million to 130 million inhabitants. In the same period the economy has multiplied its real product by a factor of 10, and per capita income has increased 4 times. However, the accelerated advance of capital production has caused serious distortions and displacements which, paradoxically, have aggravated the difficulties of the majority of the population. The unfair and uneven distribution of income is responsible for the fact that 46.4% of the economically active population receives one or less than one minimum salary (US$ 67.00), and 50% of the total population receives less than two minimum salaries (a global indicator of national income). These distortions have prevented the social progress that might have been expected and have lowered the standard of living of the great majority of our population.

The accelerated demographic expansion, the progressive urbanization of the population, which in the last 17 years has seen 70% migrate to the big population centers, the detachment from familial ties, the poor housing, the lack of proper nourishment, the difficulty of transportation, and widespread unemployment are factors of tension and conditioners of a constant increase in mental illness, mainly epilepsy, alcoholism, psychoses, and oligophrenias.

The subculture of poverty in itself, and by itself, determines a psychic mutilation which leaves the population more vulnerable to psychic disturbances and gives those disturbances a more serious aspect. Considering the vastness of the problem, and the gravity of the mental disturbances, whose incidence in our environment is calculated at 10% of the population, we are forced to take an epidemiologic point of view.

Despite the progress in pharmacology and in psycho- and sociotherapeutic techniques, the national mental health system in Brazil is based on in-patient care, stressing shelter and custody, with very few resources for out-patients.

CURRENT PATTERN OF PSYCHIATRIC CARE IN BRAZIL

Psychiatric care in Brazil, in the great majority of cases, is furnished by Social Welfare, which covers all of the Brazilian working force. The Federal Government and the state governments also offer some psychiatric care, having some in- and out-patient services. The private sector also has hospitals, most of which work with Social Welfare. Recently, under new covenants with Social Welfare, some Brazilian universities have also begun to provide medical care and training.

Though it can boast occasional innovating experiences, psychiatric care in Brazil has always been centered in the asylum hospitals which were used, and still are used, as depositories for psychiatric patients who enter to be hospitalized temporarily but end up staying as permanent or intermittent guests of these institutions.

The number of bed-days used in psychiatry increases about 15% annually, which shows a pattern of special attention to the psychiatric care of in-patients. Out-patient care has always existed, however on a much smaller scale, with the psychiatric staff usually located within the hospital, and the out-patient services functioning with just one psychiatrist, with short consultations, and without follow-up. Sometimes, in the same course of treatment, the patient is seen by different psychiatrists, with the doctor-patient relationship not established between two persons, but through a record form.

Another aspect of psychiatric care in Brazil is the great difference from one state to another, with the quality depending on economic resources, since Brazil has some areas more privileged than others, just like any other country of the third world. The utilization of psychiatric hospital beds, the priority resource of this pattern, varies from 7.8 bed-days per 1000 beneficiaries per year in Mato Grosso do Sul, to 368 bed-days in Rio de Janeiro, with a nationwide average of 227 bed-days per 1000 beneficiaries per year.

Assistance to out-patients also varies from one region to another, from an extreme as low as 9 consultations per 1000 beneficiaries per year in Maranhão. An analysis of the data on utilization of hospital beds and the care of out-patients leads us to conclude that the main factor determining the smaller or greater use is the number of beds available in the medical care network of the region.

In 1981, Social Welfare paid for the use of more than 19 million bed-days in psychiatry. That means that about 52,000 beds were occupied. In the same year, some 4 million consultations were given. Of the 3 million dollars spent in psychiatry for the services of private parties by Social Welfare, 96% was for in-patient care and only 4% for out-patient care. This modality of psychiatric care, which benefits the proprietors of the institutions, a segment of the population of great economic power, with emphasis on hospitalization, perpetuates the following distortions, in violation of the current philosophy of reorientation of Social Welfare psychiatric care, elaborated by the Consultative Board of the Health Administration in Brazil.

1 - Unnecessary hospitalizations;
2 - Great variations in the quality of the treatment offered by the hospital network, which at times fails to observe the basic rules of medical care, and may even give rise to iatrogenic acts;
3 - Compromising of the efficacy of out-patient services;

4 - Several admissions of the same patient to the system without the necessary integration between out-patient services and the hospital, and failure to use the intermediate services (psychiatric emergency, day care, and night hospitalization) which would enable the patient to spend more time in his familial environment, and would reduce the number of hospitalization demands;
5 - Absence of adequate medication, making it difficult to maintain the treatment of out-patients;
6 - Establishing the wrong diagnosis, at times leading to longer periods of hospitalization;
7 - Early medical release, with the purpose of avoiding deadlines established by the accounting system;
8 - Discharge from the hospital, and very often immediate readmission, as a way of avoiding prolonged periods of hospitalization, for which the process of payment by Social Welfare is much slower;
9 - Inadequate and priority utilization of the resources available to the State and Municipal Health Secretary of the Health Ministry;
10 - Lack of integration between psychiatry and the other clinical areas in the medical faculty, compromising medical training in general and psychiatric training in particular.

Among other elements that we can list which help explain this inadequate psychiatric care is the precarious state of epidemiological basic services necessary for effective mental health planning. Improvisation is the fundamental element of the mental health policies in Brazil.

These facts necessarily affect medical education, which often is slanted toward private practice, which serves only about 3% of the Brazilian population (those who can afford the high cost of this care). Individual psychological and psychotherapeutic techniques are emphasized in the training of medical doctors by the universities. The psychiatric curriculum in Brazil is equivalent to that of developed countries; however, the incidence and the prevalence of mental illness vary from one country to another, as do the resources available to assist the population. We have not utilized our resources, nor have we made use of all the tools that we could have used to assist the population adequately. Also the training of general practioners is sadly lacking in psychiatric information.

In the last two years Social Welfare has been concerned with the precarious condition of psychiatric care in our country. It has created a network of mental health experts, such as professors, owners of private hospitals, and psychiatric institutions, so that the social system now allows the organization of preventive psychiatric care. In January of 1983, Social Welfare presented proposals to improve the quality of assistance in the field of mental health,

making standards in rural and urban areas comparable. Assistance is to be given in accordance with established parameters and norms, permitting allocation of resources according to proposed care patterns

Among the basic principles of mental health in this mental health care program is keeping the patient within his familial, social, and cultural structure, maintaining his interpersonal and environmental relationships, considering psychiatric disturbances as episodes in the natural cycle of health and illness of the individual. The principles to be observed are:

1 - to emphasize out-patient care;
2 - to make use of a multidisciplinary staff and the various available resources of diagnostic and therapeutic services;
3 - to be sectorial;
4 - to utilize out-patient services furnished by nurses, social workers, psychologists, and occupational therapists;
5 - to make use, within limits, of the services of general practitioners in the care of mental patients;
6 - to improve diagnostic procedures, to avoid social cases mistakenly being treated as mental cases;
7 - to make use of such methods as partial hospitalization (day care and night hospitalization);
8 - to promote the establishment of small psychiatric units in general hospitals;
9 - to go from long-term custodial care to short-term treatment.

Naturally, to accomplish all these improvements, it is necessary that these principles be developed within a general reformulation of the present political, social, and economic situation in Brazil. However, it is our duty to fight for something better in the care of mental patients even if the social and political changes don't take place.

CONCLUSION

We can conclude by saying that, taking Brazil as a model, the psychiatric care of in- and out-patients is in a very unsatisfactory position. The system emphasizes in-patient medical care, isolating the individual from his social, familial, and professional contacts. The treatment received is often minimal and fragmentary, which can take the patient to a more accentuated division of his personality, promoting in a great majority a chronification of pathology, and sometimes even making sane people sick (iatrogenesis). The distortions of the medical care model hinder the effective use of the modern technological resources of science, as well as that of local and cultural resources.

We also observe the importation of models from other, more ad-

vanced cultures, which often cannot be applied to our situation. However, it is easier to adapt a model, very often one tied to large economic interests, than to begin something new, cheaper, and more suitable that can really benefit the patients.

This is the general picture of psychiatric care in the economically underprivileged countries, whose people, besides facing the problems of starvation, malnutrition, and lack of educational facilities, are more exposed to mental illness, and do not receive adequate treatment of mental disturbances.

We believe that with increased support from international organizations, if the wealthy nations of the world face up to their responsibility, we can, at least in the medical field, give some relief to these suffering and forsaken populations.

REFERENCE

1. Proposta elaborada pelo Conselho Consultivo da Administração de Saúde Previdenciária (CONASP) sobre: "Reorientação da Assistência Psiquiátrica Previdenciária" - Rio de Janeiro, Brasil, Dezembro de 1982.

CURRENT DEVELOPMENTS IN INPATIENT AND OUTPATIENT CARE IN NORTH AMERICA

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The time allotted for this presentation is too brief for an extended discussion of the complex developments in inpatient and outpatient care in North America. Consequently, I shall just touch upon the most important and crucial developments and limit my comments to the United States.

In regard to inpatient services, an outstanding development has been the shift away from state hospitals as the principal site for psychiatric treatment. Thus, in 1955 75% percent of patients received their psychiatric treatment in state hospitals. At that time, with the famous slogan "Every other bed in the United States is occupied by a patient who is mentally ill", there were approximately 750,000 psychiatric beds in state hospitals. As recently as 1965, there were 650,000 state hospital beds. By 1980 it had declined to approximately 200,000 beds. This is also well illustrated by the situation in New York State where in 1955 there were 95,000 beds, in 1965 85,000 beds, now in 1983 there are in the neighborhood of 22,000 state hospital beds. If one looks at specific treatment episodes, in 1955 49% of all psychiatric treatment episodes took place in state hospitals. By 1977 it had declined to 9%.

This trend should not be thought of as one that was capricious or a sudden inspiration; rather, it was based upon notions of long historical origin that were actively begun shortly after the end of World War II under President Truman, and reached its culmination in the Community Mental Health Centers Act of 1963, inspired largely by President John Kennedy. The goal was to establish equity in mental health services to achieve unlimited accessability and universal entitlement to treatment for all citizens of the United States

so that the poor, the destitute, and minorities could receive services equivalent to those of the wealthy. To achieve this, there were vigorous steps taken to decentralize the public psychiatric system, with the belief by some that the state hospitals would no longer be necessary. Unfortunately, no thought was given to those psychiatric patients who were too debilitated for psychiatric or medical reasons, or too violent to be managed successfully in community-based facilities, either outpatient or in community general hospitals, or various other domiciles or shelters. Thus, the process of deinstitutionalization began; that is, of releasing patients from state hospitals to their home communities. However, this was done without providing adequate local facilities. It was not only that community resources were not adequately prepared for the release of patients but there was no local funding. The primary source for psychiatric treatment are the state governments and even now with a 70% decline in the state hospital population in New York State, 90% of the state funds go to the state hospitals, 10% to local facilities. There were also other contributing forces to the decline in state hospital populations, not only for the indigent but also for middle class individuals of limited means. For them, the state hospital was the only site for their care as psychiatric patients. However, with new Federal programs in the sixties, such as Medicaid and Medicare, individuals had freedom of choice where they could get care, so they turned to private or voluntary facilities and psychiatric units and general hospitals. This trend was also speeded by certain decisions made by the courts. These included the right to treatment, the right to be treated in the least restrictive environment, and the still undecided issue of the right to refuse treatment. In the face of decisions in regard to right to treatment, a number of states drastically cut down the number of patients in hospitals, preferring that as a solution rather than meeting the standards for all the patients hospitalized.

A number of state hospitals in order to change their image calling themselves "Psychiatric Centers", and for other reasons, began to assume care for acute patients and adopted stringent admission requirements. Thus, there was no place for the intermediate and chronic psychiatric patient. For example, in New York State, the average stay of a patient in a state hospital in 1965 was 6 years; at the present time it is less than 30 days for new admissions. This has led to the "revolving door" model throughout the United States wherein patients are rapidly admitted and discharged and then re-admitted a number of times, and also a backlog of patients since very few could be admitted to state hospitals. There was an accumulation of patients in units in general hospitals with consequent difficulty in finding beds for acute psychiatric patients in large urban centers like New York City. Also, as a result of the stringency of admissions, patients were limited to those who were considered a danger to themselves or others. Thus,

the typical patient at present is a male between the ages of 20 and 50 and potentially violent.

State hospitals have ceased to assume care for intermediate and chronic patients. Where do the patients go? Anyone reading the newspapers in the United States knows that there are many former state hospital patients living and sleeping on the streets or in dilapidated hotels for single room occupancy (SRO) by patients. Cities have been inundated by a large number of homeless individuals, mostly men, who are taken care of in various shelters. In New York City the shelters are operating at 200% of capacity and studies have shown that between 30% and 40% in such shelters were psychiatric patients. Unfortunately a certain number of other patients have ended up in jails. A considerable number of the elderly who formerly might have been in state hospitals are now in nursing homes. A steadily increasing number of patients are being treated in the psychiatric units of general hospitals. The latter has been one of the most notable developments of the last couple of decades. This is primarily due to the realization following the end of World War II that no general hospital was complete without a psychiatric division, and that the care of the mentally ill was an essential part of a comprehensive health program. As has been pointed out already, changes in funding through federal reimbursement programs made it possible for a large number of patients to elect alternatives to state hospitalization, particularly for acute and intermediate care in the psychiatric unit of a general hospital. Growth of this trend is illustrated by the fact that even in 1970, 45% of the psychiatric admissions were to general hospitals, while only 32% to state hospitals. This trend has been increasing since that time.

In 1955 there were only a few thousand beds in psychiatric divisions in general hospitals, somewhere in the neighborhood of 3,000. By 1971 there were 27,500 beds in general hospitals and it has been increasing steadily since that time. By that time also, the number of treatments in general hospitals exceeded those in state hospitals.

What changes have been brought about in the care of the inpatient due to the development of these units in general hospitals? Naturally, there has been greater attention paid to the acute patient since most of the admissions were for acute episodes. Since these patients were taken care of in a general hospital milieu, one has seen a greater trend toward the integration of psychiatry with medicine in general, and also greater stimulation of interest in the basic sciences, particularly in the teaching hospitals. Greater attention is paid to psychoses that appear with physical illness, for example, lupus erythematosis. The impressive development of what is called in the United States "liaison psychiatry", or elsewhere "General Hospital Psychiatry", would require a paper in

itself. Suffice it to say that no area has so stimulated the integration of psychiatry and medicine as in those places where a successful liaison psychiatry program has been developed. The most important aspect of liaison psychiatry has been the teaching of non-psychiatric physicians and staff the emotional origins, aspects, and treatment of the physically ill, and raising their consciousness to the importance of psychiatric issues in all patients. The programs in general hospitals encourage various forms of brief therapy and particularly intensive psychopharmacological therapy. Another very important area has been the treatment of psychiatric disorders in the physically ill. Of special importance has been the recognition and treatment of depression in physically ill patients.

In regard to the outpatients, the most important stimulus for the unusual increase in outpatient services has been the development of Community Mental Health Centers (CMHC) and the introduction of effective psychopharmacologic agents. In regard to the Community Mental Health Centers, they have been much maligned, but careful evaluation reveals positive contributions as well as a number of dismal failures. Again, time does not permit full discussion of the confusing role of CMHC's in American psychiatry. But it should be pointed out that instead of the well-over 2,000 CMHC's that were originally planned, there are only 640 that were developed and many of these only in part, and as usual in the United States, elaborate long-range plans are formulated and then abandoned after a few years. Likewise, within ten years Federal funding for CMHC's has well nigh disappeared, and state and local communities are often in no position to pick up the full cost of such installations.

There is no question that Community Mental Health Centers have been responsible in part for the impressive increase in outpatient services. In 1955 23% of all psychiatric treatment were in the outpatient clinics while in 1977, it was 70%. Similarly, the number of treatment episodes excluding private practice in 1955 were 1.7 million, while in 1977 there were 6.9 million. 32% of all treatment episodes in 1977 were carried out in regional Community Mental Health Centers.

There are other contributing factors, of course, for the major increase in outpatient services. Units in general hospitals automatically developed an aftercare and outpatient service and this was much more readily done because the general hospitals are located in population centers whereas the state hospitals were in rural or remote areas very often and could not maintain effective outpatient services. Also the important development of psychopharmacologic therapy has made possible the management of the mentally ill in outpatient settings whereas that could not have been done formerly.

But there is no question that easy access to psychiatric

services for all classes and ethnic groups was facilitated by the CMHC's and particularly for the lower classes, except for the elderly. The elderly are still essentially neglected. The development of catchment areas and outreach programs were also characteristic of the recent developments in outpatient services. Also, there has been a development of convergence of all classes in which the lower classes are becoming more like the middle class in regard to seeking mental health professionals.

It should be noted however, that at the present time there is a movement away from such public care toward private services. In spite of the improved access, treatment of the lower class patient still is significantly different to that accorded upper class patients.

CMHC programs have tended more toward social models than medical models. Professional conflicts have developed as a result of the trend toward a more social model. However, there is a good deal of confusion of roles and in spite of the trend toward a social model, more drug therapy, paradoxically, has been occurring. The vast majority of chronically ill patients are receiving psychotropic drugs because of their effectiveness as well as increasing case loads demanding greater productivity. Regrettably, the psychiatrist's role in a number of places has been reduced to merely writing prescriptions. The increased use of non-physicians in many outpatient community settings is a result of a number of causes including lower costs of non-psychiatrists, alleged better rapport of non-medical personnel with lower class patients, and also the reluctance of psychiatrists to become involved with such facilities, particularly at the salaries offered.

Some of the important trends that might be mentioned in addition in outpatient care are those that are associated with their being situated in general hospitals. Increased use of psychopharmacologic agents can be seen in the development of specific psychopharmacologic clinics, depression clinics, and lithium clinics. Introduction of other modalities such as biofeedback clinics or behavior clinics must also be recognized. Emergency medicine has emerged as a specific specialty and this has led to the development of emergency psychiatric clinics, either separate or as part of an emergency medical unit. Increased attention has been paid, therefore, to the care of the acute psychiatric patient, particularly one that is violent. It has been estimated that somewhere between one-quarter and one-third of the patients seen in emergency clinics are psychiatric. Included in these are various fugue states, panic attacks, and differential diagnosis of patients with alcoholism. The differentiation of a psychiatric disorder from a physical disorder has become a most important area of concern in the outpatient clinics. Often in association with outpatient clinics there are crisis intervention units that may be mobile and take care of an entire area. Recognition and treatment of drug

reactions has become very important in the case of overdosage from legal and illegal drugs. More recently we have begun to see patients either accidentally or deliberately overdosing with psychotropic drugs. New experiences are available with the participation of psychiatrists in the emergency room in the differential diagnosis of medical/surgical patients with complex problems including psychiatric syndromes, particularly alcoholism. There also has been the development of many short term therapies; viz. brief psychotherapy, or combinations of brief therapy with psychopharmacologic agents. Walk-in clinics have been developed as well as the development of day hospitals and night hospitals and weekend hospitals in association with outpatient clinics.

In this brief overview, mention has been made of a number of ongoing trends in inpatient and outpatient care. Transcending the technical and operational changes there is the recognition of an overall convergence of psychiatry toward the basic sciences as well as toward medicine, and consequent integration of psychiatry with the basic sciences and moving toward greater integration with general medicine. This significant movement augurs well for the increased introduction of rational and more specific therapies with the differential recognition of what is most appropriate for a particular individual with a particular disorder.

With more specific therapies, the most appropriate site and method will become evident and this, in the long run, will be the most significant trend not only in American psychiatry but undoubtedly throughout the world.

THE CARE OF THE MENTALLY ILL IN AFRICAN TRADITIONAL AND TRANSITIONAL SOCIETIES

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INTRODUCTION

An observation of contemporary African reveals interesting points for Sociological and Psychological study. There are the old institutions and traditional ways. In general these are changing fast. It is only in remote areas that such cultures can be observed more or less as it was at the time of our ancestors. Then there is the new. The new is the West and West European ideas. The new way is typically described as modern. Then there is the transitional group. In this group are the majority. They share a bit of the old and a bit of the new.

AN AFRICAN VILLAGE

The object of my quest is a remote African village, unspoilt by modernity. I saw the village up on the hills set against a back drop verdant green of the forest around. There were between 30 and 40 houses arranged on the hillside about 50 yards from the river. The approach to the bridge is a slightly curved road.

The population of the village is about 200 souls. The population is either old or very young there are about 50 adult males in the age range 40 to 60 years and above. The women number about 60. They are younger and some still bear children seen, all under 7 years. They are numerous and go about with their mothers assisting with household chores. Quite a few men have more than one wife. The majority, however, have only one wife. No school was in evidence. The men reported that their grown up children have left for various towns and cities in search of employment or education. They aim to better the lot of

their fathers and village. They hope to return to the village in the distant future.

SOCIAL ORGANIZATION

There is the village head or "Odionwere". He owes alligiance to the traditional ruler some miles away. An odionwere is a son of the area and is the oldest living individual in the defined area. The next in order of gerontocracy becomes the deputy and the next and then the next. The social system is organised in terms of age groups. In the normal run of events this class of elders will have next to it the warrior class, youngmen in their prime then will name the class of youths.

Traditional healers in the village saw their function as:- to ward off evil forces such as witches and wizards and to keep the forces of nature in balance and harmony. "You young educated people are knowledgeable in books but you do not really understand or know the world. We pray for you that the world does not know you or become interested in your affairs. There is much more to the world than meets the eye. There are mighty spiritual forces". Before any events occur here in the visible world it has first happened in the spiritual world; the fates of people decided and all activities concluded first before they begin to happen here. The spirits have been created by God almighty himself. All the spirits both good and evil are created by God. Everyone comes into the world with a destiny which must to a larger or smaller degree be fulfilled. Traditional healers hold communion with the spirits and ferret out the destinies of men, make appropriate sacrifices and ameliorate or change the fortunes of men". This is the lot of traditional doctors. It is a hazardous occupation, communicating with spirits in this way. The priests have to have have special spititual preparations for this role if they are not to come to harm. Traditional healers also give food to immediate departed ancestors to appease them so that they can cast a favourable eye on the present generation, protect and guide them.

THE WITCHES

Witches and wizards play a central role in African cosmology and day to day life that a word or two should be said about them. A sample of medical students surveyed showed that these students all believe in the presence of witches in the community and cite many examples of confessional statements reported in the popular press. From all accounts witches exist to do harm. They terrorize the victims through the capacity to cause illness and misfortune, childlessness, poverty and death. Witches are female but males exist but these are called wizards. Witchcraft is believed to be acquired by eating witches substance in the food or drink. It is more common in some families than others. The legend is that

witches select for their victims members within their own families, sharing in the feast of others and offering victims from their own families at the appropriate time.

Witches are provoked to act on by the commission and omission by the victims. Sudden acquisition of wealth, rudeness to elders, boasting, offending elders, sudden success, selfishness, greed, failure to invite strangers to share in food, failure to greet, acquisition of property without appropriate placetion of ancestral spirits and usurpation of the rights of the first born. The general belief is that there is some infraction or impropriety, however slight.

Witches in true traditional society are therefore judicial agents serving to warn and punish offenders.

WESTERN CULTURE IN THE AFRICAN SETTING

The characteristics of the group of westernised Africans include a prolonged period of schooling extending over 15 years in the majority of cases. The majority of the educated western elite and normally christians and operate in the wage sector of the economy. They occupy the higher administrative positions in the bureaucracy, medicine, law, universities and occasionally in business. The majority have had a length of stay in Europe and admire western ways of life and institutions, with a desire to replicate these in Africa. In Europe an important arsenal of westernisation is the protestant ethic'. The doctrine proclaimed by Max Weber emphasises honesty, hard work, and frugality and accumulated surpluses being used to produce more wealth. The educated western elite nominally share these beliefs. In some important aspects this group differs from their European counterpart, in that there is no overriding material or philosophical interest. The common denominator for the group is the capacity to afford and maintain a western way of life for themselves and their children

THE TRANSITIONAL GROUP

Probably this is no group at all but rather the group of people who have left the traditional social systems of their ancestors and now in pursuit of the western way of life but for one reason or the other have not yet "arrived".

The most important attribute of the group is the desire to be like the educated western elite. Institutions have developed within the community thtat cater for this group. These are the revivalist group of churches, who have evolved a way of combining the advantages of devination, casting out witches, wizards and evil forces but without the devination systems of traditional

systems. Instead of the diviners board they use the bible. The song and dance follow traditional patterns but the hymns are taken from Christian book of songs. Practitioners see visions or dream dreams or hear voices and speak in tongues. These enable the practitioners to be warned of impending dangers and catastrophes.

EMPIRICAL STUDIES

These reports concern themselves with whether western diagnostic categories usefully apply to African patients. So important is the topic of delivery of mental health care that the Association of Psychiatrists in Africa organised a special workshop on "The delivery of Mental Health Care". It was clear that the conference was concerned with the furtherance of western type institutions in Africa. The participants recognised that the models of the West would have to be utilised but would have to be modified to suit local conditions.

There have been reports of alternative forms of care from Lambo, Binitie and Swift. Lambo first reported on the village at Aro. Reports of variants of the village system have come from Binitie who described a therapeutic neighbourhood in Benin and Swift who described the building of a new village for psychiatric rehabilitation.

TRADITIONAL THERAPEUTIC SYSTEM

Reports about psychiatry in Africa mention the role of traditional healers in the care not only of psychiatric disorders but of physical ailments as well. Field, in her study or rural Ghana showed the central role played by the traditional healers, in rural life, both for the prevention and treatment of disease. Sacrifice is prescribed to ward off evil and potions and draughts given to cure sickness and encourage health. Reports from all parts of Africa suggest that the role of traditional healers is similar. Concerning their power to tame the witches and control the forces of evil in the communities, explanations have also been offered. Alland (1965) in a study conducted in Ivory Coast found that witches kill their victims out of envy or jealousy. Pritchards book Witchcarft, Oracles and Magic among the Azande reported ..... 'charges of witchfraft thus reflect personal relations and quarrels'.

There have been reports on the use of drugs by traditional healers. Prince (1960) reported on the use of rawolfia alkaloids in the treatment of psychiatric disorders.

DISCUSSION

There is the educated elite whose goal in life is to be a European, to adopt a European attitude to life, establish European institutions and lead a genteel sophisticated western life. There is within the culture, however, powerful social forces at work which serve to emphasise his Africanness.

The true traditional African feels secure in his culture but finds no material satisfaction. His institutions provide spiritual satisfaction and an understanding of the environment within the framework of the world as seen through traditional eyes. He seeks the material comforts of the Western ways and in the process loses his Africanness and is enmeshed in a new world where no solace is offered and no security possible.

The transitional group, caught in the middle between the old and the new have tried to synthesize a new way which incorporates the ways of old with the new. They have borrowed freely from the Christian or Islamic religion but utilise traditional African vehicle of devination, rituals, songs and dance and the expulsion of evil spirits.

The problem viewed in another way can be stated thus, the entire social system is in a social flux and hence the institutions within the system. The majority of citizens no longer know quite where they belong. In the course of a single episode of illness therefore it is not unusual for an African to run through the entire spectrum of available therapeutic systems.

REFERENCES

1. Asuni, T. (1969): Methods of Delivering Mental Health Care. Conference Paper on Delivery of Mental Health Care. Kampala Ugada April 14-17.

2. Binitie, A. (1971): Experiments in the development and Planning of Psychiatric in the Bendel State of Nigeria. Psychopathologie Africaine.

3. Binitie, A. (1971): A Study of Depression in Benin City, Nigeria. MD Thesis London University.

4. Binitie, A. (1981): Psychiatric disorders in rural practice in the Bendel State of Nigeria. Acta Psychiat Scand 64 273-280.

5. Bohannan, P. (1960): African Hormcide and Suicide. Princeten University Press.

6. Boroff Ka (1969): Different ways of starting Mental Health Care. Conference Paper on Delivery of Mental Health Care Kampala Ugadan. April 14-17.

7. Beroffka, A. (1970): Psychiatry in Nigeria Today and Tomorrow. Nigeria Medical Journal Vol.7 (4) 36-39.

8. Carothers, J.C. (1953): The African Mind in Health and Disease. Menograph Series No. 17 Geneva WHO.

9. Collomb, H. (1965): Introduction a la Psychiatrie Tropicale. Med Trop 16 141-151

10. Collomb, H. (1965): Psychiatrie en Afrique (experience scnegalesc) Psychopathologic Africaine U 84.

11. Field, M.J. (1960): Search for Security: An Ethrographic Survey of Rural Ghana.

12. Forde, D. (1963): African Worlds, Oxford University Press.

13. Forster E.F.B. (1962): The theory and practice of Psychiatry in Ghana. American Journal Psychotherapy 16 7-51.

14. Fortes, M. and Dieterten, G. (1965): African system of Thought. Oxford University Press.

15. Gluckman, M. (1944): The Cogie of African Science and Witchcraft, an Appreciation of Evan Pritchard 'Witchcraft, Oracles, and Magic Among the Azande'. Rhodes Hivingstene Journal No 1 June 61-71.

16. Gerden, M.L. (1936): Inquiry into the Correlation of Civilisation and Mental Disorders in the Kenya Native East. Afric Med. J. XII 325-327..

17. Lambo T.A. (1956): Neuropsychiatric Diservation in the Western Region of Nigeria.

18. Lambo, T.A. (1960): Further Neuropsychiatric Observation in the West Region of Nigeria BMJ II.

19. Lambo, T.A. (1961): A Form of Social Psychiatry in Africa. World Mental Health 13.

20. Lambo, T.A. (1961): A Paln for the Treatment of the Mentally ill in Nigeria. The Village System at Aro. In Linn L.

21. Lanbscher BJF (1937): Sex Custom and Psychopathology. London: Routledge and Keegan Paul.

22. Leighton, A.H. Lambo, T.A. Hughees C.C. Leighton, D.C., Murphy J.M., Maclin B.D. (1963): Psychiatric Disorder Among the Yoruba. New York: Cornell University Press.

23. Margetts E.L. (1965): Traditional Yoruba Healers in Nigeria. Man 102 July-Aug. 572-3.

24. Nadel, S.F. (1952): Witchcraft in four African Societies, An Essay in Comparison. American Anthropologist 54 18-29.

25. Peel, J.D.Y. (1968): Aladura: A religious Movement Among the Yoruba. Oxford University Press.

26. Prince, R. (1960): The Use of Rawolfia for the Treatment of Psychoses by Nigerian Nature Doctors. Amer. J. Psychiat 117 147-149.

27. Prince, R. (1964): Indigenous Yoruba Psychiatry in Kiev, A Magic Faith and Healing London. Free Press of Glencoe.

28. Shelley, H.M. and Watson, W.H. (1936): An Investigation Concerning Mental Disorder in the Nyasaland Native With Special Reference to Primary Ecological and other Contributory Factors. Journal of Mental Science LXXXIV 701-730.

29. Sofowora, A. (1979): African Medical Plants, Proceedings of a Conference. Ed. Sofowora: Ile-Ife. University Ife Press.

30. Swift, C.R. (1969): Village Settlements for Conoalescent Psychiatric Patients: Conference Paper in Delivery of Mental Health Care. Uganda April 14-17.

31. White, A. (1969): Unpublished
A Partly Annotated Bibliography: Psychiatry in Africa.

COMMUNITY MENTAL HEALTH HOME-CARE PROGRAMME, HAIDIAN DISTRICT IN THE SUBURBS OF BEIJING

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INTRODUCTION

The mental health home-care program refers to the community mental health services with which the mental patient is cared for at home with suitable treatment and nursing. The purpose of our studying this problem is trying to find a more practical way to help the mental patients in our rural communities where the mental health services were especially not so adequate.

In order to develop this pilot program for study several points were put into consideration:

1. In the course of treatment, patients who suffer from mental illnesses are in special need of sympathy, understanding and concern of those around them. In other words, they need support not only from medical workers, but also from their family members, friends and from the community. If they are deprived of the opportunity to take part in the activities of collective and live in an isolated way, the result of the drug treatment can hardly be consolidated. They might have relapses. In order to keep them from falling back, community mental health care is absolutely necessary.

2. According to Chinese cultural tradition, all the members in a family have closer relations to each other than people in the west. They usually take it as their duty to help one another economically as well as in other respects. They tend to think it is their responsibility to take care of those members who are ill. As a rule, the family wouldn't think of sending their sick

relatives to mental hospital. So, in China, most of the mental patients are kept at home and looked after by the other members of the family.

3. In China, under the health princeple "Prevention First" and "Serve the Broad Masses", there have been already quite a number of primary health care centres in the urban and rural communities. There is a hospital for each commune which covers the inhabitants ranging from 10,000 to 40,000. Under the commune hospital, there are several health centres with barefoot doctors in each production brigade or village.

The integration mental health service into primary health care was taken as the principle of development of community mental health care in this study, so that the mental health care services as one component of comprehensive medical service in the community.

METHODS

In June 1974 we began to set up a health care net for mental patients in 11 people's communes at Haidian District with a total population of nearly 190,000. A series of procedures have been taken:

1. Training. The psychiatric training of primary health workers were: barefoot doctors from health centres trained for 1 week and medical workers from commune hospitals trained for 4-6 months.

2. Field survey. Psychiatric interview of each suspected case was carried out by experienced psychiatrists from our institute togather with the primary health workers in charge. Severe mental patients were identified with established case-record. It was found that the prevalence of schizophrenia(1.82%) has been prominent among all functional psychoses and prevalence of mental retardation(2.57%) among all organic mental disorders in Haidian District. The prevalence of other mental disorders were: manic-depressive psychosis, 0.07% ; reactive psychosis, 0.26% ; epilepsy and epileptic mental disorder, 2.10% ; and other psychoses, 0.27% .

3. Treatment. Majority of these indicated patients were treated at their home under natural living environment after propagating the knowledge of mental health among their family members. While giving the patients various kinds of treatment, the doctors and barefoot doctors paid visits to their families from time to time. If the patient's condition had been improved, we'd encourage them to join in more social activities as early as

possible. They either did some household work or took part in some collective labour. A special program for the treatment and prevention of relapses for schizophrenia was put into practice.

4. Evaluation. At the end of each year, all patients had been followed up to evaluate the effects of treatment and social functioning. From Dec. 1981 to Feb. 1982, an intensitive investigation was carried out in the largest commune in that district. The traditional forms of interviewing, PSE and DAS brief version were used and the Chinese traditional diagnostic criteria of mental disorders, ICD-9 and DSM-III were also compared.

RESULTS

Establishment of Mental Health Care Net

Through nearly three years strives(1974-1977) by all health units and staffs related, an effective and efficent mental health care net was established and a functional system and work rules were gradually formed among the related members of the net. Table 1.

Additionally, a number total of 254 barefoot doctors and 14 doctors were trained with the skills of mental health service during the period of 1974-1979. The average ratio between the number of barefoot doctors trained and the population of village was 1:750, while between the number of medical worker of commune hospitals and commune population was 1:13,000. Owing to personnel changes, we carried out a new training program over 28 primary health workers of two communes from 1982 to 1983. Thus the staffs of primary health units have been improved significantly.

Short-term Effects of Treatment

From 1974-1976, 211 schizophrenic patients were treated with neuroleptic drugs in combination with home-care and good remission and marked improvement had reached 64.9%. It was close to those recieved treatment in our hospital in the same period.

Long-term Effects of Treatment

Follow up studies in the successive nine years proved the effects of treatment of mental disorders by the home-care net to be maintained steadily. As illustrated in Table 2. the percentage of good remission and markedly improved of various years were still above 65.

The mean value of schizophrenic patients readmitted from 1976 to 1982 was 3.4% per year.

Table 1. The Mental Health Care System in Haidian District of Beijing

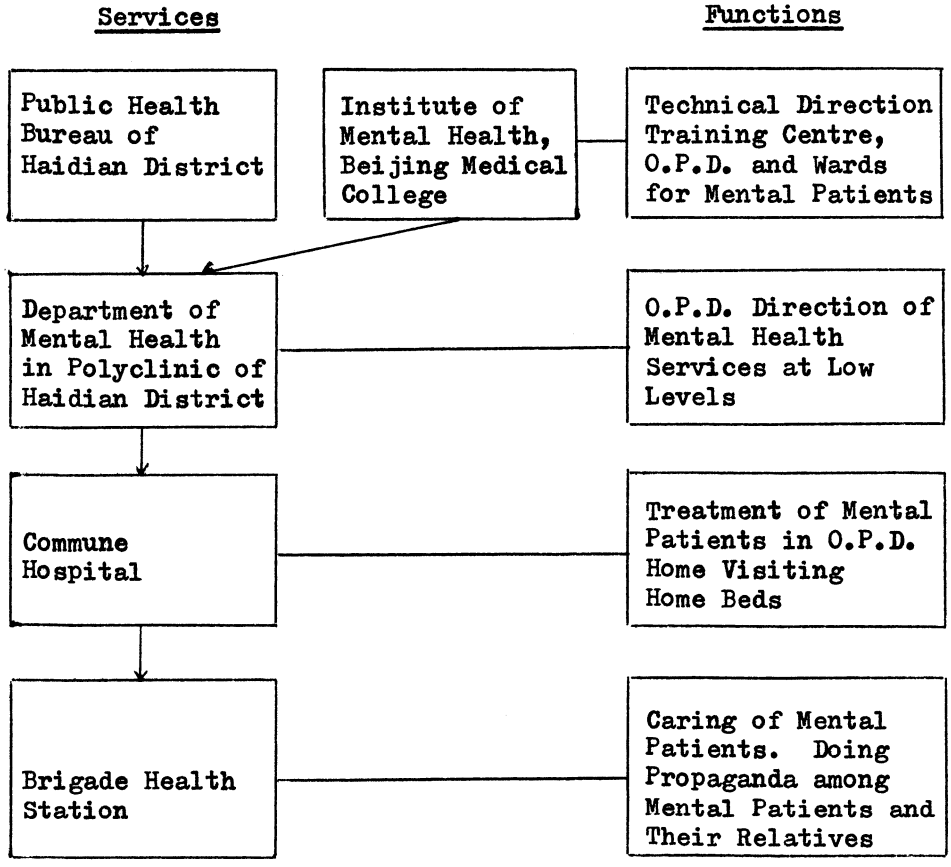

Table 2. The Therapeutic Effect of Schizophreniacs in Successive Years (1976–1982)

Year	No. of Patients	Remission No. (%)	Markedly Improved No. (%)	Improved No. (%)	Not Improved No. (%)
1976	211		137(64.9)	54(25.6)	20(9.5)
1977	232	102(44.0)	69(29.7)	44(19.0)	17(7.3)
1978	234	115(49.1)	51(21.8)	59(25.2)	9(3.8)
1979	206	74(35.9)	66(32.0)	52(25.2)	14(6.8)
1980	231	71(30.7)	86(37.2)	53(22.9)	21(9.1)
1981	332	94(28.3)	121(36.4)	81(24.4)	36(10.9)
1982	361	130(36.0)	105(29.1)	73(20.2)	53(14.7)

Recovery of social functioning of patients is the main aim of our mental health services. Exactly, the patients serviced by the mental health care have been acquiring satisfactory recovery of social functioning. Before the program was initiated only 2.9% of schizophrenic patients were able to do normal farm work on a full time basis. However, at the end of 1979, this percentage rose to 47.1; and from 1979 to 1982, it were 37.6 to 47.1.

Evaluation of the Program Results

At the end of 1981, the results of an intensive study of 99 schizophrenic patients in the Sijiqing Commune, compared the traditional way of evaluation of clinical state and social functioning with PSE and brief version of DAS, showed that previous clinical evaluations were in good agreement with the scoring of PSE and DAS. The results of the home-care in the 7th year were still satisfactory: 36.4% in good remission; 41.4% in marked improvement; 13.1% improved with some psychotic symptoms: and 9.1% still of either psychotic symptoms or deteriorated. And the recovery of the patients in their social and family functioning in this commune at the end of 1981 was about the same of 1979 for the whole Haidian District.

At the same time, we had also compared the Chinese diagnostic criteria of schizophrenia with ICD-9 and DSM-III. Although ICD-9 and DSM-III seemed slightly narrower than ours, the effects of treatment remained almost the same.

DISCUSSION

1. By a long-term of nine years continueous practices, the community mental health home-care program has been proved successfully as a feasible and practical way of solving the problem that mental health service are far from adequate in rural areas.

2. The advantages that the community mental health home-care program has exhibited are mainly as follows:

(a) Owing to the actual causes of some mental disorders, especially schizophrenia, are yet unclear, it is natually to stress on the second level prevention for mental disorders. How to keep the good effects of treatment therefore becomes the key to prevent relapse which is the main point of the second level prevention for mental disorders. Our program acquired actually this effects of treatment with less relapse. At the end of the first year of the home-care service, good remission and markedly improved reached two thirds and has been maintaining since then. This is close to those of our institute's hospitalized patients

during the same period. Furthermore the relapse is rather low that could be revealed by the data 3.4% of average number of patients readmitted of Sijiqing Commune from 1976 to 1982. Conversely, the reports of 14 psychiatric hospitals in China in 1964 said the relapse rate of shizophreniacs two years after discharge in average ranged from 29.9% to 51.7%, and even rose up to 53.6% or 76.7% if the patients had been followed up for 4 years or 10 years.

(b) Whenever there is a new patient or fluctuation in the mental status of patient or an occurrence of family conflict, the necessary drug therapy and/or counseling would been provided by the primary medical personnel in the early stage. So the relapse of mental disorders could be abated.

(c) Convenient to patients, saving time and saving money, are also the good points of this program. Patients could be treated on the spot without being sent by their relatives to see the doctors in city. It is no longer need to pay a lot for admission in hospital in city but only a little payment for drugs used in home-care if required. Clearly, early recovery of social functioning can contribute undoubtedly economic advantages to patients themselves, their community and whole society as well.

3. The fairly good results we have obtainted in our research program probably explains:

(a) Not only social activity and family support are the important factors in the social rehabilitation of the mental patients but also the effect as a commune member in participating social activities on the psychological state of patients should be emphasized.

(b) China has her good cultural tradition under which members in a family keep a close interactions with each other. Once the preexisting bias and negative attitude towards the mental illness corrected by the popularizing mental health knowledge among the family members of patients, the active cooperation from patients' relatives could be then ensured.

(c) The activities of the primary mental health workers who service in a well developed primary health care system play an important role in the reducing of relapsing rate of mental patients. Getting them well trained with the professonal skills of detecting and managing the mental patient can help the above role carry out successfully.

PSYCHIATRIC MORBIDITY IN A MENTAL RETARDATION UNIT

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KEY WORDS

Mental retardation- Psychiatric morbidity- Personnel - Cost & benefit - Epilepsy- Aggression- Affective disorders- Conduct disorders- Community care.

MATERIAL AND METHOD

The presence of psychiatric disorders in a mentally handicapped person is often overlooked, misdiagnosed or inadequately treated. The study included 31 in-patients at a private hospital (Hekma) for the mentally handicapped in Cairo, in which a network of medical, psychological, educational, speech therapy, physiotherapy, occupational and recreational horizons exist and reflect the perspectives viewed for the mentally retarded in 1982. The various caring staff and professional disciplines were involved in the study and all made a valuable contribution to this work. Patients who could not be interviewed because of communication difficulties were assessed by short frequent contacts for observation of their gestures, postures, social responsiveness and activity levels over 3 months duration.

HOSPITAL PERSONNEL

One Consultant supervisor, 2 psychiatrists, 1 physician, 1 dermatologist (twice weekly), 1 pediatrician (twice weekly), 15 sisters (2 shifts), 15 maids (2 shifts), 2 cooks, 2 porters, 1 food supervisor, 1 teacher, 2 communication (speech) therapists, 2 physiotherapists, 1 psychologist. The staff :patient ratio 47 : 30 i.e. 1.5 : 1

RESULTS & DISCUSSION

Out of the 31 retarded patients, 21 were males (67.7%) and 10 were females (32.3%). The mean of their ages was 11.2 years, with a minimum of 1.5 year and a maximum of 35 years. They were classified according to I.Q. (Table I),

TABLE I : Distribution of patients of the study according to I.Q. (American Association for Mental Deficiency):

Borderline (84-70)		Mild (69-55)		Moderate (54-40)		Severe (40)		TOTAL
No.	%	No.	%	No.	%	No.	%	
3	5.6	6	19.2	15	48.3	7	22.9	31

In the present study, 11 retarded patients (35.9) manifested epilepsy. This result is in agreement with the conclusions made by Penrose (1) who showed that approximately 30% of the residents in any mental deficiency hospital will be epileptic. Seven of the epileptic retarded patients (63.6%) showed grand mal type, 2(18.2%) manifested subclinical epilepsy in EEG only, psychomotor and salam fits presented themselves in one case only.

Ounsted et al. (2) and Eyman et al. (3) found a special association between epilepsy in retarded patients and overactivity and aggressiveness. Our results were consistent with their findings as it showed that aggression as a symptom was found among 10 epileptic retarded patients (90.9%), 13 males (61.9%) and 8 females (80%) i.e. about half of those who presented with aggressiveness (47.6%) were epileptics, but not with the study of Corbett et al. (4) who reported this association to be negative. Moderately and severely retarded patients showed more aggressive behaviour (76.2%).

Evaluation of the sample studied, though it was a small one, revealed that 13 cases (42%) had no psychiatric disorders, while 18 retarded patients (58%) manifested psychiatric disorders superimposed on mental retardation. This percentage is consistent with the figures available, and this high rate may realise the urgency for admission to a hospital of a mentally retarded person as noted by SHHD & SED (5) (Table II).

Table II : Demonstration of Psychiatric Disorders Superimposed on Mental Retardation in the study sample.

	Psychiatric Disorders on M.R.	No.	%
A.	No psychiatric disorder other than M.R.	13	42.0
B.	Psychiatric disorders on M.R.	18	58.0
	1. Hyperkinetic syndrome	2	6.4
	2. Early childhood autism	3	9.7
	3. Depression	3	9.7
	4. Hypomania	2	6.4
	5. Schizophrenia	3	9.7
	6. Organic catatonia	1	3.3
	7. Neurotic disorder	2	6.4
	8. Conduct disorder	2	6.4
	TOTAL	31	100.0

Hyperkinetic behaviour was detected in 8 cases (25.8%) and hyperkinetic syndrome was found in 2 cases (6.4%), a result that goes with those of Corbett (6) and Reia (7) who estimated that over 8% of the severely retarted children showed hyperkinesis.

Early childhood autism was present in 3 cases (9.7%) and all were boys, of severe retardation. This prevallance rate exceeds much that of other workers (8, 9, 10, 11) who arrived at a prevallance rate of autism of 4.5 per 10,000 children aged 8-10 years. The small number of cases included in this study may be responsible for this difference in prevalence.

Several workers (1,12,13,14,15,16,17,18,19,20,21,6) affirmed that manic-depressive disorders could occur in retarded patients, a matter that was confirmed by our study as depression was diagnosed in 3 cases (9.7%) and hypomania in 2 patients (6.4%).

Some workers (22,23,24) noted that manic-depressive disorders start earlier and recur more frequently, and this early presentation might be facilitated by the structural brain abnormality (25). As the mean of the ages of the study sample shows, the early onset was noticed.

In the opinion of Hayman (26) and Herskovitz & Plesset (16) schizophrenia cannot be diagnosed on clinical grounds in patients with an I.Q. much below 50. Penrose (26) agrees but notes that typical schizophrenic psychosis can occur in mildly retarded patients. Reia (18) and Heaton-wera (20) have stated that it is impossible to identify subgroups of schizophrenia, while Earl (27) & Shapiro (28) have maintained that simple schizophrenia is particularly common. Reid (18), Heaton-Ward (20) and Corbett (6) reported a point prevalence rate for schizophrenia of 32-35 per 1000. In the present investigation schizophrenia was detected in 3 cases (9.7%), 2 cases were of undifferentiated type and were of mild and moderate degrees of retardation, while the third was of the schizoaffective type, borderline intelligence was rated in this case.

Abnormalities of behaviour and problems with restlessness, noisiness and self-injury are also encountered widely in mentally retarded patients, particularly in the severe retarded ones (29, 30, 7) and was estimated to be in more than 20% (31). Hierons et al. (32) suggested that abnormality of B-endorphin system may be a relevant factor, as it may be that excitement might mediate the production of B-endorphine leading to diminuation of pain sensitivity, thereby facilitating self-injury. Diminished pain sensation was detected in one case of a mildly retarded female aged 6 years.

Emotional disorders in retarded patients of any age in which reality sense is preserved, including state of disproportionate anxiety, panic, phobias, hypochindriasis, misery, unhappiness, depression and relationship problems as sibling jealousy were shown by several investigators (7, 32). Corbett (6) reported that 4% of the severely retarded children were suffering from neurotic disorders. In our investigation, neurotic disorders per se were detected in 2 retarded patients (6.4%), in whom hypochondriasis was the prevailing symptom.

Conduct disorders involving aggressiveness and destructive behaviour including delinquency, minor sexual misdemeanours and other socially unacceptable behaviour that is not part of any other psychiatric condition were described by Rutter et al. (33).Corbett (6) reported that its prevalence is 4% of severely retarded patients, and Reia (7) found that 27% of retarded out-patient children manifest it. Two cases (6.4%) in our sample manifested conduct disorder per se.

The existence of psychopathy as a clinical entity is disputed and Clare (34) has pointed out many of the discrepancies in this concept. Earl (27) was one of the earliest clinicians to recognise deeply engrained maladaptive patterns of behaviour and marked eccentricities that stem from an imbalance of components of personality, taking the form of schizoid, immature, unstable, explosive, paranoid or anxious groups. Corbett (6) estimated that 4-25 %

of the retarded adults in the Camberwell survey manifested as personality disorder. No cases with personality disorder were revealed in the sample, this may be due to the small number of cases studied, the protective attitude and psychological management inside the hospital atmosphere and lastly to the relatively young age of the whole group, a matter that may be apparent by time as the patients grow older.

CONCLUSION

Mentally retarded patients manifested psychiatric symptoms with great frequency, a factor which may determine family care or hospitalization. In our unit every patient costs about 350 dollars/ month.The average monthly income of an Egyptian is 35 dollars and so we can infer that all our patients were from the neighbouring petrodollar countries. Egyptians can afford a few weeks on a daily basis.

The model running of mental retardation unit is very costly and more emphasis on community care after control of medical and psychiatric problems should be implemented. Formation of classes for mentally retarded children in ordinary schools is necessary to promote community care, relieve isolation and rejection and to continue an educational and rehabilitation progress not hampered by financial restraints.

REFERENCES

1. L.S. Penrosel : A clinical and genetic study of 1280 cases of mental defect. Special Report Series of Med. Res. Council, 1938, No.229, HMSO, London.
2. C. Ounstead, J. Lindsay & R. Norman : Biological Factors in Temporal Lobe Epilepsy. Cinics in Developmental Medicine. No.22 Spastics International.
3. R.K. Eyman, L. Copas, B.C. et al. Moore, : Retardates with seizures. Am. J. Ment. Def., 1969, 74, 651-9.
4. J.A. Corbett, R. Harris & R.G. Robinson : Epilepsy. In, Mental Retardation and Developmental Disabilities, Vol.III ed. Wortis, J., Brunner Mazel, New York, 1975.
5. SSHD & SED : A Better Life. Report on services for the Mentally Handicapped in Scotland. HMSO, London.1979.
6. J.A. Corbett :Psychiatric morbidity and mental retardation. In, Psychiatric Illness and Mental Handicap. Ed. James, F.E. & Snaith, R.P. Gaskell Press, London, 1979.
7. A.H. Reid : Psychiatric disorders in mentally handicapped children : a clinical and follow-up study. J. Ment. Def. Research, 1980b, 24, 287-98.
8. V. Lotter: Epidemiology of autistic conditions in young children. I. Prevalence. Social Psychiatry 1966, 1, 124-37.
9. V. Lotter: Epidemiology of autistic conditions in young children. Social psychiatry 1967, 1, 163-73.

10. B.H. Brask :A prevalence investigation of childhood psychoses. In Noraic symposium on the care of psychotic children. Barne psychiatrist Forening, 1972.
11. L. Wing : Early Childhood Autism. Pergamon Press, Oxford, 1976.
12. A. Gordon: Psychoses in mental defects. Am.J. of Insanity,1918, 75, 489-99.
13. Prideaux, E.: The relation of psychoneuroses to mental deficiency. The J. of Neuro & Psychopathology, 1921, 2, 2o(-20.
14. A.G. Duncan : Mental deficiency and manic-depressive insanity. J. of Mental Science, 1936, 82, 635-47.
15. J.C. Rohman: Mental disorder in the adult defective. J. of Mental Science, 1936, 82, 551-63.
16. H.H. Herskovitz & M.R. Plesset : Psychoses in adult mental defectives. Psychiatric quarterly, 1941, 15, 574-88.
17. R. Payne: The psychotic subnormal. J. of Mental Subnormality, 1968, 14, 25-34.
18. A.H. Reid: Psychoses in adult mental defectives : I. Manic-depressive psychosis. II Schizophrenic and paranoid psychoses. Brit. J. Psychiat., 1972, 120, 205-12 and 213-18.
19. S.J. Hucker : Pubertal manic-depressive psychosis and mental subnormality. brit.J. of Mental Subnormality, 1975, 21, 34-7.
20. A. Heaton-Ward : Psychosis in mental Handicap. Brit. J. Psychiat, 1977, 130,525-33.
21. A.H. Reid & G.J. Naylor: Short-cycle manic-depressive psychosis in mental defectives : a clinical and physiological study. J. of Mental Deficiency Research, 1976, 20, 67-76.
22. C. Perris : A survey of Bipolar and Unipolar Recurrent Depressive Psychosis. Acta Psych.Scand.,Suppl.194.Munksgaard, Copenhagen,1966.
23. S.J. Hucker: K.A. Day, S. George et al: Psychosis in mentally handicapped adults. In Psychiatric Illness and Mental Handicap, eds. James, F.E. & Snaith, R.P. Gaskell Press, London, 1979.
24. M.T. Tsuang , G. Winokur & R.R. Crowe : Morbidity risks of schizophrenia and affective disorders among first degree relatives of patients with schizophrenia, mania, depression and surgical conditions. Brit J. Psychiat., 1980, 137, 497-504.
25. A.H. Reid : Diagnosis of psychiatric disorder in the severely and profoundly retarded patients. J.of the Royal Society of Med., 1980a 73, 607-9.
26. L.S. Penrosel: The Biology of Mental Defect. 4th.ed. Sidgwick& Jackson, London, 1972.
27. C.J.C. Earl :Subnormal Personalities.Balliere Tindall,London 1961.
28. A. Shapiro: Psychiatric illness in the mentally handicapped:an historical survey. In, Psychiatric Illness and Mental Handicap eds. James, F.E & Snaith, R.P., Gaskell Press, London, 1979.
29. A.K. Mutter, D. Peck, D. Whitlow et al: Reversal of a severe case of self-mutilation. J.of Ment. Def. Res.,1975,19, 3-10.
30. M.A. Matin & A.T. Rundle:Physiological and Psychiatric Investigation into a group of Mentally Handicapped Subject with Self-

Injurious Behaviour. J. Of Ment. Def. Res., 1980, 24, 77-85.
31. B.R. Ballinger: Minor self-injury. Brit. J.Psychiat., 1971, 118, 535-8.
32. A.D. Forrest: Neurosis in the mentally handicapped. In, Psychiatric Illness and Mental Handicap, eds. James, F.E. & Snaith, R.P., Gaskell Press, London, 1979.
33. M. Rutter, P. Graham & W. Tule: A Neuropsychiatric Study in Childhood. Spastics International Med. Publications. Heineman Medical, London, 1970a.
34. A. Clare: The concept of mental illness. In Psychiatry in Dissent. Tavistock Publication, London, 1978.

METHODS OF ESTABLISHING MANPOWER REQUIREMENTS IN PSYCHIATRIC HOSPITALS: INVENTORY AND FUTURE PERSPECTIVES

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INTRODUCTION

The next future for psychiatric hospitals seems to be more demand for less beds with the same amount of personnel or eventually a reduced number.
What kind of influence these developments have on the quality of care? How to defend the same number of personnel for less patients? How to explain, that there is a need for more? How to get insight in the supply and demand for care?
It is my intention to describe in this short paper some research and practical experiences on the field of manpower needs in psychiatric hospitals.
They are related expecially to people working in the wards busy with treatment and nursing care, the primary proces of an institution.
Other members of the personnel for example in the administration are left out of consideration.

SUPPLY AND DEMAND FOR CARE

On a ward demand and supply are determined by patients, therapists, nurses and other providers eventually. The patients ask for help. They are complaining about psychic or somatic problems and try to cope with them. They translate their need for help in questions (demand) for care. They expect this care for taking away annoying symtoms of illness and for personal problems as a human being.
The therapists translate the complaints of the patients in professional care via a treatment plan.

This will be based on problems the patient putted forward, but also on ideas about causes of illness and questions the patient isn't fully aware of.
The therapist brings additional convictions of himself by his expertise. In his eyes these are equally important for a good treatment result as giving a plain and direct answer to demand for care of the patient only.
Beside this professional care the therapist gives personal support. His expertise is not needed, when he procures this.
The expertise of the nurses answers the demands for nursing care of the patient and the instructions of the therapists at the same time.
The general supply of nursing care is directed to those needs of the patient who are connected with survival such as: to eat, to sleep, to drink, to rest and to be active.
Beside it help is offered for psychic and somatic problems. These services can be needed on a regular basis, for example in the case of a continuing disability and an incidental one. Conversations and personal support are not a must always. They can be postponed or left of. In this way a difference can be made between fixed and variable activities.
Demand and supply are often not in equilibrium with each other. At one time the demand is big and the supply inadequate. In that case the patient will be neglected. At another moment the supply will be extreme. The patient gets such a quantity of care, that he feels himself oppressed. He is hampered in his self-help and grows care dependent.
It is a responsability of the ward-management for tuning demand and supply. Striking is the often heard complaint of a personnel shortage. Too many questions ought to be answered obviously. So feelings of failing are starting and being deficient in the full-filling of the task. Research showed, that these frustrations are often conncected with instructions of the therapists. If they prescrible for exemple, that a patient, who walks badly, has to exercise four times a day with the help of a nurse, they don't realise themselves, that it could be impossible to put these instructions into practice. The same is true with new therapeutic methods.
A nurse has other tasks to perform also. It is plausible to suppose, that her days work is filled up totally. A new task is being added. Which one can be putted aside? This leads to the result, that the instructions are executed partly or not at all.
It will be clear, that a situation like this gives rise to guilt feelings who are translated in an urge for more people.
The patients demand for care can be too high also. An example can be found in the help for psychogeriatric patients. Many of them are incontinent and need to change clothes or to get clean sheets regularly. This happens often insufficiently, certainly in the eyes of family members.

Here the question of the quality of care comes up. What kind of aims are persued? Has the patient to be dry always? Or is it allowed, that he or she is wet a couple of times? Which limits have been formulated?
So a shortage can be connected with a quality standard, which is too high related to the quantity of personnel.
It is a management task also to fix the standards and to write down the goals of care. Without doing this it is impossible to know the bounderies and to test the practacability of the arranged purposes. In this way one can diagnose too much care and too little.
For the supply is important also, the organisational structure of a ward.
Finally some remarks about the building in which the care happens. A nurse needs more time to answer a question if he or she works in a huge and complicated structure with long and near endless corridors, than in a smaller one, where everything is near. The time for walking and cleaning eventually shortens the time for caring the patient.

METHODS AND MEASURES

The situation in the Netherlands is, that there has been looked for a solution of the supply and demand along three ways. In two cases research projects are on the way, which will be ended soon. In one case a method has been developed, which is used now in several hospitals and has proved its value in practice. None of them covers per se all the previous called factors.
The first research project is being executed by the Dutch National Hospital Institute. It is named "Modules and Structures". The goal is to get insight into treatment and care packages (modules), specialised wards (structures) and the personnel numbers belonging to them.
The organisations of all the Dutch psychiatric hospitals have been investigated and compared to learn about different wards and treatment programs in them. Striking was the enormous variation in names and size in relation to numbers of patients. An observation ward for admissions in one institution can differ extremely from the same in another hospital of comparable extent. Goals of treatment and care are different also.
Clear descriptions were needed to permit comparison.
The second project, which shall be finished soon, is directed on evaluation of treatment and nursing care.
What kind of results have been reached by a given number of personnel? Are they improving by increasing or decreasing it?
Three instruments have been developed. One for measuring the niveau of functioning of patients. Via a repeated use of it results and effects of treatment can be diagnosed.
A second instrument serves for registration of demographic and biographic patient features to characterize patient groups of different treatment programs.

The third registers the use of people relating to activities, methods and technics. The total project combines treatment and care effects with the number and devotion of personnel. Many factors about demand and supply mentioned above will be negotiated at the end. The project has been executed in the psychiatric hospital "Santpoort".
I shall try to describe you a method now, being used a couple of years already. It was introduced by the psychiatric hospital "Veldwijk". Starting point is, that demand and supply in a ward are given facts. No statements are made about the quality of care. The investigator, a work-analyst, looks at processes and the time needed by somebody to perform his task. A difference has been made between primary processes, such as treatment and nursing care and supporting processes such as meetings, reports and house-keeping. Together they are the characteristic variables of a ward.
The processes are connected with goals and organisation structures. They are dependent on the building also.
To realise the different processes a worker gets a task. This can be measured in time. By comparison of similar tasks a norm is stated. A task contains fixed and variable activities, who are named and formulated in the several spots, where they are accomplished.
Time can be translated in number of workers. Are all the tasks realised? If the answer is yes, no more people are needed. If it is no, the contrary is the case.
Interesting is also, that with this method the number of personnel needed for new treatments, can be considered. An exact planning is possible.

THE FUTURE SITUATION

It will not be possible no more for psychiatric hospitals in the near future to base the justification for their activities on vague stories about treatment results. They will be obliged to give insight into quality of treatment and care, into their efficiency and outcome. This is true certainly speaking about personnel-needs. Therefore good management is a prerequisite.
Striking is, as the research in the psychiatric hospital "Veldwijk" showed, that nurses and others are not conscious of the use of their time. They know the beginning and end of a work-day, but are not aware of time in relation to the realisation of tasks. Often they operate ad hoc. They leave a started occupation and don't come back to it later. A new situation asks their interest suddenly. A conversation with a patient for example. The duration will be as long as needed. Sometimes short but sometimes very long also.
It seems to be important that nurses, doctors and therapists learn to use their time more efficiently and care for a better division of their activities during a day. Doctors loose many minutes by

coming and going through the hospital responding to all kinds of unexpected questions based on the rule of being on call for everybody on any moment.
Another phenomenon is, that there are peaks in a work-day of nurses. There is one between seven and nine in the morning and others are during the meals. For the periods in between the situation in a ward is much more quiet.
If the nursing staff could use more time for peak hours they would have less feelings about shortage. Education in time management is significant.
The research projects and the practical method I described will need extension in the future. May be it is a possibility to integrate them all. Together they cover nearly all the factors of demand and supply mentioned and answer the questions of evaluation of results correlated to quantity and quality of staff.
In the policy and planning of psychiatric hospitals they will play an important role more and more. Eduction programs are needed to integrate methods of measurement in the daily practice. The same is true for management development.

REFERENCES

Blanpain, J.E., "Ondergaan tegengaan of voorgaan", Acta Hospitalia 1983/1
Reports of research of the "Dutch Hospital Institute", the mental hospital "Santpoort" and the mental hospital "Veldwijk".

THE IMPROVEMENT OF THE LEVEL OF STAFFING IN MENTAL HOSPITALS IN THE COURSE OF FURTHER REDUCTION OF BEDS - A CONCEPTIONAL AND A POLITICAL ISSUE

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Professionals in mental health services are always running the risk to become part of the problem that they are to solve. Patients, relatives, different groups and institutions of society confront them with contradictory demands which are often symptomatic of the individual disease, of the disturbed communication in the family of of pathogenic living conditions.
Frequently the expectations can be reduced to the formula: cure, but don't change anything at all or even: cure by segregation and suppression . Many patients want to recover but refuse to handle their conflicts. Families want the best for their mentally ill member but at the same time make him the scapegoat of the whole family. Society proclames reintegration and practices ostracism of its weakest members. Being caught between contradictory demands may become a double bind situation:
Many collegues are dissatisfied with their working conditions. They know that e.g. longterm hospitalization does more harm than good, but they keep quiet. They are afraid that public discussion of the deplorable situation of their patients and of mental health institutions would cause an additional strain on the patients and additional restrictions for themselves.
Keeping quiet brings about a vicious circle of decreasing trustworthyness. It consequently intensifies the deformations of mental health institutions, so that people not involved in the system ask themselves who is more sick and insane: the patients or the institutions which should cure them.
Above all, there is a serious shortage of staff. The training of mental health personnel in public institutions is insufficient. Being but poorly equipped they are bound to care for the most disturbed and desintegrated patients. Treatment is often compulsory. In order to accomplish their task they have to engage in personal

contact with their patients, allying to the healthy part of the patients personality without being manipulated by the sick part.
They have to deal with the family in an appreciative and impartial manner, without becoming involved in pathological interactions. They are to promote the social integration of their patients and to strengthen the potential of self-help of patients, families and the community. They must manage severe conflicts, which are introduced into therapeutic teams especially by psychotic patients. They have to struggle for adequate working conditions, which means an integrated system of inpatient, outpatient, rehabilitative, and complementary services amply supplied with staff and equipment.
If this is not attainable to an adequate degree because of the working conditions, they should, last not least, have the courage to return responsibility for psychiatric care to operative authorities, insurance and social security authorities and politicians.
In other words:professionals in mental health services miss their commission as far as they are not able to face up to their personal, interactional and political conflicts.
The task of providing efficient and humanitarian care for the most mentally disabled is difficult and needs support from the outside.
A thorough reform of mental health services can only be achieved in an area, where it is supported by a social reform movement.
These considerations are illustrated, taking as an example the reform of the mental hospital, focussing on manpower requirements.
There is international agreement that large state hospitals are obsolete. It is a controversial issue, however, how small the mental hospital or psychiatric department at a general hospital should be in the future. In any case the centre of gravity in mental health services is moved from the hospitals to outpatient, rehabilitative and complementary services. In the Federal Republic of Germany, where this process is developing very slowly, the staffing situation in mental hospitals remains to be of strategic importance.
According to the recommandation of the German Hospital society from 1969, which is still accepted as guiding rule by most authorities , the nurse to patient ratio should be about 1:3, as it is in general hospitals. The ratio physicians to patients should be 1:12 for intensive care, 1:26 for regular care and 1:51 for a long-term care. Although these ratios are inadequate the actual staffing numbers in many mental hospitals are still worse.
In this situation the directors of the public mental hospitals in the Federal Republic of Germany called for public and political attention.
In 1982 a working group has elaborated the framework of a concept of manpower requirements in mental hospitals. It was derived from the functions of modern inpatient psychiatric services and contains new staff to patient ratios. Types of wards and fields of therapeutic work were described in a way, that should enable politicians and administrators to understand how much staff time for which kind of work would be necessary and what could be done by a certain number of staff and what not. In 1982 this concept was unanimously passed by

the association of directors and subsequently published (Bergener et al., 1982).
Changes in the functions of mental hospitals from a custodial to a more rehabilitative approach exact new forms of care. The mental hospital has to provide for an integrated system of medical, psychotherapeutic and sociotherapeutic services. The three fields of therapeutic work are defined: basic medical care, environmental therapy and individual therapy.
They are overlapping, of course.
Basic medical care (by physicians and nurses) includes all diagnostic measures, pharmacotherapy as well as other somatic treatments, catering, help with personal hygiene, clothing and self-support, observation of patients at risk.
Environmental therapy, which comprises social, productive and creative activities ans sports as well as ward meetings and group psychotherapy, should make the hospital a therapeutically effective medium.
In addition and from the beginning of treatment individual therapy must focus on reintegration including individual and family interviews, home visits, consultations of employers, local authorities etc..

These requirements will only be met by the cooperation of different professions, especially physicians, nurses, psychologists, social workers, occupational therapists.

Treatment must be comprehensive and continuous which necessarily calls for teamwork.
Team conferences should be held daily, especially on admission wards. Relatives, social and medical extramural services, private practitioners etc. must be contacted frequently. Consequently the time spent on indirect care, that is care not in face-to-face contact with the patient, amounts to up to 5o% of the working time.
An estimation of staffing requirements has to consider the specific disabilities of the patients as well as the treatment objectives of the unit concerned.
Therefore 16 different types of ward are defined, the most important being a standard admission unit, a standard rehabilitation unit, a day hospital, a gerontopsychiatric unit, an alcohol/drug addiction unit.
The number of staff required corresponds to the time needed for the three different fields of therapeutic work: basic medical care, environmental therapy (including all group activities), and individual therapy. This time again depends on the several factors of influence, which must be considered: the number of occupied beds, the admission rate, the needs for special nursing, custodial and medical care.
In the psychiatric department of a general hospital in Bremen we examined the real distribution of staff time.
The results were compared with the requirements according to the concept of the association of directors (Fig. 1 see column "needed").

Distribution of stafftime		admission unit		rehabilitation unit		day hospital	
		actual	needed	actual	needed	actual	needed
Basic medical care	physicians, hours/ patient/week	1,5	2,5	o,2	1,7	o,2	o,4
	nurses, no. present during daytime for medical care only	1,4	2,5	1,5	2	1,2	1
Environmental therapy	hours/patient/day	2,o	2,5	3,3	4,o	4,4	4,o
	patient/staff ratio	5,5:1	3,5:1	12:1	5,8:1	6,2:1	4,5:1
Individual therapy	hours/patient/week	1,5	5,5	1	4	1,8	4,5
staff	total number (24 beds/places)	13,5	25,3	8,8	17,o	8,3	12,4

Figure 1.

This is demonstrated for 3 characteristic units.
Because of lack of manpower restrictions in all fields of therapeutic work had to be made. Concerning basic medical care the difference of the actual and the needed staff is obvious. The average hours per day which patients spend in group activities is close to the needs. The ratio of patients to staff, however, is still much higher than recommended, especially in the rehabilitation unit. The time available for individual psychotherapeutic or sociotherapeutic treatment is about one third to one fourth of the time needed.
It may be concluded that therapy still is focussing too much in the patients behaviour in the hospital and too little on his life at home. Viewing the lowest line of the figuere the reason for this deficiency becomes obvious. The existing number of staff meets the demands to about 5o-75 %.
Complementary to these quantitative date we have studied qualitative deficiencies, too.
Patients with acute medical and physiological problems do not receive the intense care they need and are exposed to unnecessary compulsory measures as e.g. locking of doors and increased sedation.
Physically handicapped patients and patients with lack of initiative cannot be mobilised and activated enough. The lack of training of self-support and of other social capabilities is deplored. The staff members report, that they do not relate to relatives in adequate measure, and that necessary home visits, meetings with neighbours and employers can only seldom be carried out. On weekends there is too much idling on the wards. The keeping of records is fragmentary.
Although these results can be regarded as typical for mental hospitals throughout the entire Federal Republic of Germany, in some parts permanent staff reduction was enforced.
The directors have objected to this proceeding emphatically stating that "the burden of the economic crisis is passed on those who are least able to defend themselves, as e.g. psychiatric patients."
They remind the administrative authorities of the hospitals, the insurance and social security authorities, the legislative bodies as well as the public that mentally disturbed citizens still cannot be provided with an appropriate modern treatment and that it is their duty to ensure the adequate money for manpower supply of the mental hospitals.
This statement can be viewed as a sign that psychiatrists begin to understand and exercise their political functions.
In the concluding chapter of the paper they take a further step by analysing structural problems in the mental health system. In their view the system of financing mental health services stands in sharp contrast to the task of developing a comprehensive network of community oriented mental health services.
Because of the mutual interdependance of the different mental health services a resolution of the structural problems can only be found through an integrated system of financing the entire regional mental health care.

The budget of the different services should be financed out of a pool to which health insurance, annuity insurance and social security contribute.
The distribution of money should be controlled by the mental health board of the community. This way of funding is thought to be the best one to guarantee an improvement of care for the most disabled patients and to make limitation of costs possible. It should be preferred to reimbursement for definite units of care.
The number of beds required for standard mental health care can be lowered further from the present 1.5 to o.5 per looo population presupposing a regional network of ambulant services, sheltered housing, vocational rehabilitation services and recreational services. Regional mental health planning would comprise regional staffing plans, of course. On the long run the centre of gravity of staffing distribution has to be moved from inpatient services to extramural services. In the beginning, however, reduction of beds must not be followed by reduction of staff until the staffing requirements of the mental hospital are met.
These structural considerations show that fundamental changes in the political field are necessary if the reform of mental health care is to be conducted along the guidelines of the enquête on the state of psychiatric services of 1975.
Since the publication of the report numerous efforts have been made to obtain public and political support. Several associations of professionals and experts in the mental health field have backed the proposals: the German Society of Social Psychiatry, the German Society of Psychiatry and Neurology, the Board of Psychiatry of the German Hospital Society and the Association of operating authorities of mental hospitals.
Even if the wave of financial cut-backs in the system of social services will reach the mental health services inspite of the high backlog demand in this area, it has to be appreciated that the directors of mental hospitals as a group have begun to engage in political conflicts in order to improve working conditions and the quality of care in mental hospitals. This fact can be regarded as a beginning change in attitude which might increase mental health in mental hospitals.

REFERENCES

M. Bergener, H.P. Kitzig, P. Kruckenberg, M. Rave-Schwank, G.Ritzel, W. Werner, Personalbedarf im Psychiatrischen Krankenhaus. Aufgaben und Ziele einer zeitgemäßen psychiatrischen Behandlung, Psychiat. Prax. 9 1*-16* (1982).

TARGET SYSTEMS OF PSYCHIATRIC INSTITUTIONS AND MANPOWER REQUIREMENTS

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1. INTRODUCTION

In this paper, we present a rough draft of an instrument, which might be helpful for making decisions, concerning manpower requirements in psychiatry. This instrument is a model of all the kind of work, that is to be done in a psychiatric hospital, if we want to translate our modern concepts of psychiatry into reality. The speciality of this instrument - which makes it different e.g. from a written concept on the same matter - lies in the fact, that it tries to illustrate all important elements in a visualized form simultaneously. For the understanding of the model a few facts about the psychiatric reform in Vienna have to be mentioned.

2. THE REFORM OF THE MENTAL-HEALTH-CARE (MHC) SYSTEM IN VIENNA

The psychiatric reform in Vienna is going on since about five years. The basic organisational ideas of this ongoing reform are:

2.1 Vienna is divided into eight catchment areas (CA)

2.2 The out-patient care of the different CAs is being done by so-called "Psychosoziale Stationen" (PSt). These are social-psychiatric units, which are located within the CA, they are responsible for. They are run by the "Kuratorium für Psychosoziale Dienste in Wien" (PSD), a body of private law, financed and controlled by public authorities.

2.3 The in-patient care of the different CAs is being done by the psychiatric hospital, we work at. It is called "Psychiatrisches Krankenhaus der Stadt Wien - Baumgartner Höhe" (PKH-BH) and is the biggest psychiatric in-patient insti-

tution in Vienna and for the population of Vienna. The main part of the MHC for the Viennese population - at presence 1,5 million inhabitants - has to be provided by this hospital. Every department (DEP) of it is responsible for one CA.

2.4 The DEP of the PKH-BH and the PSt. of the PSD responsible for the same CA have to cooperate.

This in a very simplified form is the organisational essence of the reform of the MHC system in Vienna.

3. CONSEQUENCES OF THE VIENNESE PSYCHIATRIC REFORM FOR THE ORGANSIATION OF THE PKH-BH

As we said, the different DEPs of the PKH-BH have to take care of the in-patients of a certain CA. In the PKH-BH the DEPs care for their patients happens within four types of wards: wards for acute and wards for longterm patients in general psychiatry, wards for gerontopsychiatric patients and wards for mentally retarded patients.

4. WARD CHARACTERISTICS IMPORTANT IN CONNECTION WITH MANPOWER REQUIREMENTS

At this point - when talking about wards - three factors have to be considered in connection with manpower requirements in psychiatry.

4.1 The Number of Patients to be taken Care per Ward (or - more general - per Unit)

The wards in our hospital at present have an average capacity of 40 patients. The average employment of capacity also should be taken into account.

4.2 The Rate of Patient Movement

The wards - especially those, which are responsible for acute care in general psychiatry - have to do with a different number of patients coming into and leaving the ward in a defined span of time, e.g. per day. Bergener calls this factor "Index of Passage". We talk - as already mentioned - of the "Rate of Patient Movement", which varies in different wards substantially. The variation e.g. in general psychiatric acute care has among other reasons to do with different size and sociological structure of the CAs. These differences among the CAs cause a variation of absolute administrative incidence between 1,8 and 3,2 patients per day.

4.3 The Number of Patients (or the Percentage of Patients) who have a Special Demand for Medical and Nursing Capacities

It makes a difference e.g., how many patients in a geronto-psychiatric ward have to be fed, bedded, intensively treated with pharmaca and so on. Such differences have to be considered, when wanting to realistically staff such a unit.

5. A FUNCTIONAL MODEL OF A STANDARD IN-PATIENT WARD IN THE PKH-BH

After referring these general facts about the reform of the MHC system in Vienna and its consequences within the PKH-BH, including a short charcterization of the wards, we can now present the model, we talked about at the beginning of this paper. It is shown in figur 1, which covers two pages. The model consists of two parts, the first of which shows the important elements of the patient-system (the term system should stress the fact, that we in most cases have to do with patients and their families), the second of which contains the necessary functions in connection with the new MHC system in Vienna.

5.1 The Patient-System

The vertical arrows above and below the word "patient-system" symbolize, that the patient in many cases is only a temporary element of the care system. On the left edge of the model the points of intervention are enlisted: the "body", the "enviroment" and the "inner world" of the patient. As to the body, the in-patient psychiatrist (in a wide sense) actually fulfills three roles at once - first that of a general practitioner, when psychiatric in-patients become somatically ill, second that of a doctor of internal medicine or of a neurologist if there are patients e.g. suffering from diabetes or having had a cerebral insult, both going along with psychiatric symptoms and third that of a psychiatrist (in a narrower sense) e.g. when treating patients with acute psychoses with neuroleptics. These three types of interventions directed towards the body of a patient are usually called somatotherapy. - The interventions directed at the environment of the patient we have divided into two dimensions, one covering the everyday life of the patient, the other having to do with the hospital life of the patient. "Living" and "working" outside of the hospital, that is within every day life corresponds in the hospital with the "individual sphere" and the "activities" of the patient within the hospital life. We call interventions, which aim at finding a place to live or to work for the patient "milieu-" and "acitivity-manipulation", to stress the fact, that the important thing is, to place the patient somewhere. We talk of "milieu-" and "activating-therapy" on the other hand, when we think of trying to train the patients activities within the hospital and help him, to

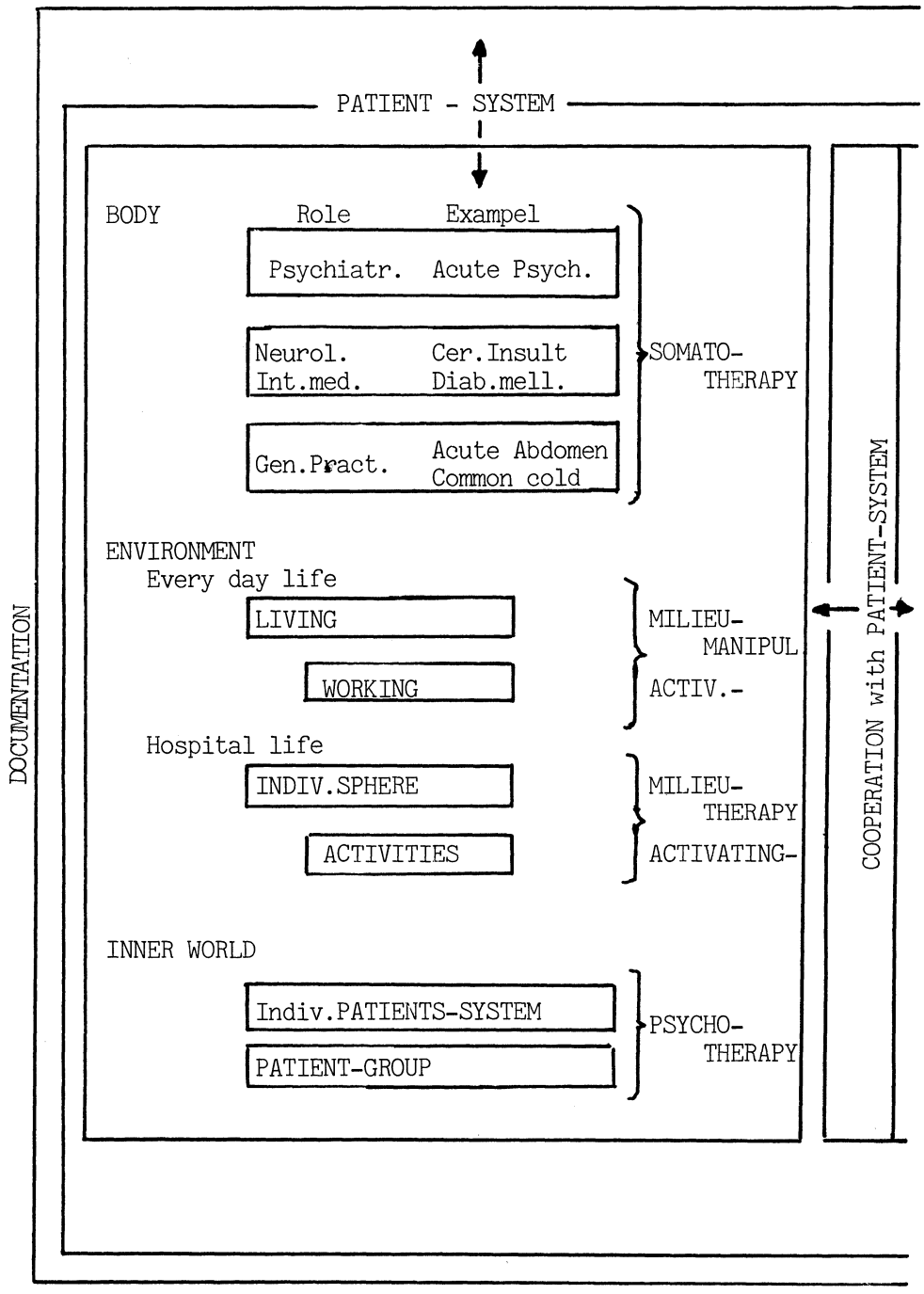

Fig. 1: Functional model of a standard in-patient ward

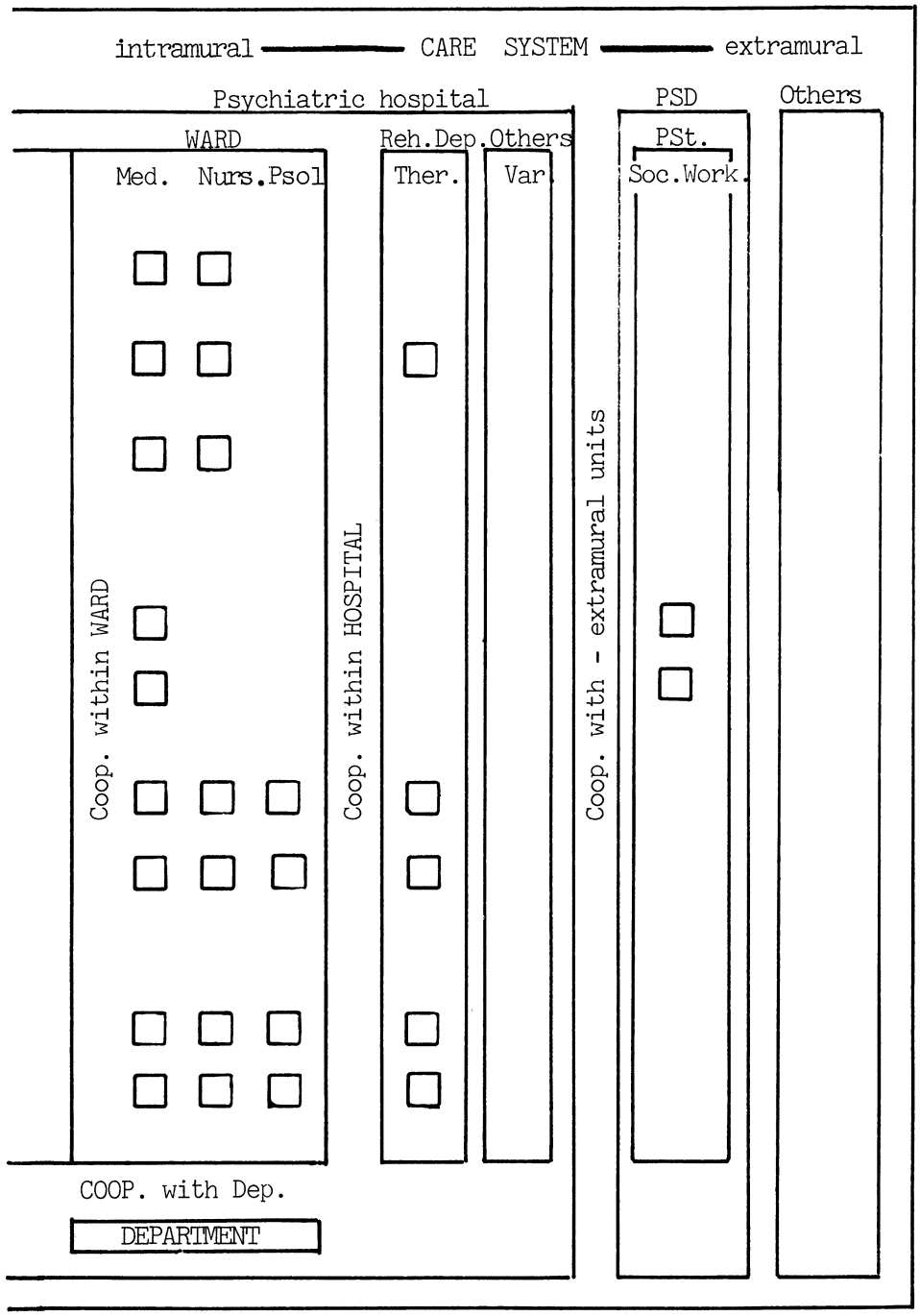

Fig. 1: continued. - The squares symbolize the different professions engaged to fulfill a certain function.

make use of his "individual sphere", that is, to flexibly change between retreat to privacy - as far as possible in the hospital - and joining the group. - Interventions aiming at the "inner world" of patient-systems are usually called "psycho-therapy". With this term we only mean intensive forms of psycho-therapy. All other kinds of what is often called psycho-therapy, we include into "cooperation with patient-system", which is written sideways and includes all oral, written and organisational efforts to inform patients about the already mentioned items, but also about the care system. The horizontal arrows symbolize that.

5.2 The Care-System

The different forms of therapy or manipulation and the cooperation with the patient-system overlap already with the care system. The right side of the model deals with it. Intra- and extramural subsystems (IM, EM) form the total care-system. The IM subsystem (the PKH-BH) is divided into "ward", "department", "Rehabilitation Department" (REH-DEP) and "Others". The EM subsystem shows the "PSD" and "Others". Four types of cooperation are divided: 1. cooperation within the ward, 2. cooperation of the ward with the other parts of the DEP, 3. cooperation of the ward with other DEP in the hospital, 4. cooperation of the ward with EM units. Several roles are mentioned within the different units - "medical, nursing and psychological" staff in the ward, "activating therapist" in the REH-DEP, "Social worker" (SW) in the PSD and "Variant partners" (VAR) in "Others".

5.3 Documentation

All the above mentioned functions have to be documented. This is being symbolized by a frame around patient- and care-system on which sideways "documentation" is mentioned.

6. APPLICATION

As we said, this instrument can be used for improving decision-making in an issue like manpower requirements in psychiatry. Besides this, we also use it for training and controlling purposes. This model could be one of the steps to target systems of psychiatric institutions, which in many cases do not yet exist.

INTRODUCTORY REMARKS ON THE CURRENT STATUS OF THE SCHIZOPHRENIAS

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In welcoming you to this symposium on Current Aspects of Treatment, Research, and Social Considerations of the Group of Schizophrenias, I first wish to pay tribute to the late Professor Fritz Freyhan who would have given the paper on the Phenonomenology, Natural course of the illness and Diagnostic Views in fashion in different countries, which follows these introductory remarks. Professor Freyhan died in December 1982 and is sorely missed by his colleagues all over the world. I would ask you to join me in a moment of silence to him and to his memory.

The Group of Schizophrenias are human disease with acute, subacute and chronic forms. There are no complete animal models for this illness. It remains therefore in all respect an illness that is human. Even today approximately 12.5 to 15% of all hospital beds around the world are occupied by patients suffering from this illness, many in its chronic and residual forms. It has an overall average world-wide morbidity of roughly 1% of the population, though this varies greatly, according to the diagnostic criteria used. There is no specifcally curative, or definitevely curative, therapy for this condition at present. We have however many extremely useful, helpful, and partially effective, partial curative, treatments for these conditions. These have reduced the length of hospitalization greatly and allow many people to live (often with residual symptoms) in the community rather than in a mental hospital. The importance of spontaneous remission in this disease at all its phases, and the possibility of this occurring is important; and must not be lost sight of. The importance of different types of successful therapies which can be applied to selective patient populations at particular times during acute episodes needs stressing. Often these treatments function partially at least in terms of the personalities of both the

patient and of the physician or other treating personnel involved in the treatment. By this I mean when they are successful, patients and physicians have often selected each other for their mutual capacity to work together over time.

It is a fact that we do not presently have a specific curative therapy, and there are large numbers of residual, as well as acute, schizophrenic patients with partially or totally uncontrolled symptoms. Living with this disease, with its thought disorder, its introversion, its withdrawal from the world into a private world, its greater predilection for fantasy as compared to reality, remains the fate of many. Its dissociation, autism, ambivalence and ambitendence, and the overall tendency to deviate biological energy from creative adult tasks into personalized defensive operations that maintain the disease is characteristic. For many patients characterological defenses forms a psychotic way of life. These psychotic characterologic patterns pose massive problems for the patients and their relatives. The massive problems for the patient and their families poses massive problems for the particular society in which they live. In this sense, in its demand for services, and need for beds even today with neuroleptic treatment and a push for deinstitutionalization, Schizophrenic patients still occupy 12.5-15% of all hospital beds, particularly in the developed countries. This is an example of the terrible burden that the need for services, and the terribly complex social and political problems that this disease imposes on societies in their attempts to deal with the demands and the needs of patients with this illness. Here the Group of Schizophrenias are a good model for all psychiatric illness and for the complexities that psychiatric illnesses pose for the local social scene.

In the rest of this symposium one will hear "On the natural course of the illness", the paper to have been given by Professor Freyhan but will now be given by Professor Sarwer-Foner; the Current theoretical views on genetics, epidemiology and some treatment concerns from Professor R. Cancro, Biological and Pharmacological Therapies of the Schizophrenias by Professor H.C.B. Denber; On Rehabilitative Treatment of Residual Schizophrenic Patients, Outpatients Community therapy by Professor Mary V. Seeman; and Treatment and Civil Commitment in the United States by Professor Emmanual Tanay. This symposium will end with the discussion of Social Policy problems: Organizing adequate Treatment Services, problems of patients in the Group of the Schizophrenias, by Professor Sarwer-Foner. (This ends my introductory remarks).

PHENOMENOLOGY AND NATURAL COURSE OF THE SCHIZOPHRENIA GROUP OF ILLNESSES, DIAGNOSTIC VIEWS AND FASHIONS IN DIFFERENT COUNTRIES

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Using an Eugene Bleulerian type of orientation to the Group of the Schizophrenias it is important to note that Schizophrenia has characteristic tendencies and characteristic symptoms, with a spectrum or spread of these, and a range of intensities in their symptoms. It can come in a light ("Fruste"), form, or develop all the way to a full-blown form. It is very important to remember that it can stop, start, or remit at any stage of its development. (1) In its fullblown form it represents a full panoply of the tendencies and symptoms that this this disease shows.

In developed countries up to 1955, Psychiatry has as mush as 50% of all hospital beds, and patients with Schizophrenic illnesses occupied roughly half of these. Thus Schizophrenic patients occupied roughly 20-25% of all hospital beds. By 1983, less than 25% of all hospital beds were for Psychiatry, and less than 12.5% of all beds were used for patients with Schizophrenia. In place of these hospitalizations, many Schizophrenic patients are now in non-medical welfare facilities in the community such as hotels, boarding houses, group homes, jails(15), penitentiaries, instead of hospitals. Schizophrenic patients, nevertheless, represent roughly 1% of the population if one takes a world view, although there are marked variances to this from country to country. It is in every country a prime of life disease, with the ages of 19-40 showing the maximal incidence. One must remember that 1% of patients are children under 13 years of age. The social recovery, or discharge from hospital, statistics vary from country to country, and for the acute forms of the disease today, show a 40-80% recovery range. This wide discrepancy is accounted for by the type of tratment and treatment facilities offered. In state hospitals it is often a revolving door type of phenomenon with

roughly an overall 40% recovery rate, while in some of the better staffed general hospital units or private hospitals with high doctor to patient and staff to patient ratios, recovery from an acute episode is as high as 85%. In Eugene Bleuler's classic data, from 1805 to 1905, 60% showed a normal social recovery, (what he called "mild deterioration"), 22% showed "moderate deterioration", while 18% showed "severe deterioration". The Worcester State Hospital of U.S.A. data of 1833-1846 showed a rather similar type of data in the report of Dr. John R. Parke in 1893 in the "Moral Therapy" days; (2) showing "a good recovery phase" set in, in the post industrial revolution period which persisted up to the neuroleptic era, (roughly after the 1900's to the current neuroleptic era after 1953).

Today, in 1983, for the residual form of the illness, one can say, using Goldberg and Hogarty's data (4,5,6) that roughly 70% of patients can stay out of hospital mostly with residual symptoms, for three plus years when treated with neuroleptic drugs and "sociotherapy" - a program to help them socialize, develop living skills and sometimes work skills. (4,5,6). However 20-25% stay out when given a placebo alone. Thus neuroleptic drug treatment allows roughly 50% of Residual Schizophrenic patients to stay out of hospital. The polarizations that have always faced and continue to face researchers working on eitological factors in Schizophrenia continue to exist, and have been explored in my Simon Bolivar Lecture. (13) Space and time do not permit repeating them here in detail. The issues of this disease are one of: 1) changes in the brain cells, genetic, metabolic, biogenetic, metabolic set and therefore organic, producing inevitably the signs and symptoms of the disease because the brain cells are first organically affected? 2) is the disease produced by emotional conflicts, which at a defensive human level, given genetically determined sensory, reactive defensive gaiting styles, produce secondary, to-and-fro passing-in-time, functional physiological changes, ego defensive changes, which in turn influence the brain physiology, thereby "psychogenically" produce or influence the disease, its signs and symptoms? Today, one can only say that some patients fit one while others fit the other of these two possibilities better.

Schizophrenic morbidity and current Schizophrenia symptomatology

Though the group of Schizophrenias have a roughly 1% incident across the world, if you look at the statistics (2,12), they vary considerably in some countries, reflecting in this, what is called "Schizophrenia" in a particular country. Thus the overall incident for Europe is about 0.85%. It going from 0.45% in Germany to almost 2.45% in Switzerland. These differences reflect the way the diagnosis is made and the theoretical view of what the disease is. Included in this is the issue of what psychopathology is to be included or excluded from this diagnosis. In classic German

psychopathology, the so called German Schools, following the work of Kleist (8), Jaspers (7), and Leonard (10,11), Schizophrenia is looked at from the point of view of signs and symptoms, which are studied in their own right, with or without necessarily having a central coordinating theory, other than these signs and symptoms are probably neuronal in origin and therefore "organic". Many of these authors are very critical of E. Bleuler's original concepts in this regard. Many followers of the later German schools feel E. Bleuler's concepts and those of Adolph Mayer allowed inclusion of a much larger group of patients, many with recoverable illness, than the German schools' visualization of Schizophrenia (Dementia Praecox). Thus they tend to reserve the term Schizophrenia, or Demential Praecox following Kraeplin, for severe ongoing and therefore to become chronic patients (Process Schizophrenia). (9) They use a variety of terms for Schizophrenic-like episodes, "Schizophreniform" episodes in which the patients have affect and good prognosis, and these they call Reactive Schizophreniform psychoses, Reactive Schizophrenia or other non-Dementia Praecox terms, i.e. "their" Schizophrenia diagnostic terms. This also includes such terms as Latent Schizophrenia, etc.. Kurt Schneider's first rank symptoms, (14) although designed to obtain better diagnostic operational categories, and were to be used for diagnosis only (first rank taking precedent over second rank "for diagnosis only"); identify, as his critics have pointed out, only advanced cases of Schizophrenia. Understanding some of the complexities of these differences accounts for why and how statistics vary from country to country. North American Psychiatry, and to a lesser extent British, are much more like the Swiss Bleulerian influences school. In North American with an Adolf Meyerian, Eugene Bleulerian and a psychodynamic heritage, we include some cases of the diagnostic category of Schizophrenia which some German psychopathologists would exclude. This explains the differences between the German morbidity statistics of roughly 0.45%, the overall European statistics of Europe at 0.85% and our North American statistics which run approximately 1% and the Swiss statistics which run as high as 2.4% of the population.

Do we see all subtypes of Schizophrenia today? In Western countries we see Schizophrenia, Simple Type, and we see a lot of Schizophrenia, Paranoid Type. Very few classic Hebeprenic patients are seen except occasionally in a "Fruste" (slight, or very mild) form. One almost never sees the severely deteriorated state hospital patients anymore. How much of this was an iatrogenically induced product of hospital allowed regression in chronic state hospitalization becomes a moot point. Modern neuroleptic treatment and relatively rapid discharge, orientated towards social rehabilitation and focusing better attention on the patterns of regression lessens this in todays hospital settings, in Western countries, provided these medical facilities have adequate medical and nursing manpower for their programs of non-regressive rehabilitation of the

Schizophrenic patient. Schizophrenia, Catatonic Type, is seen relatively rarely today in Western countries compared to what was seen 30 years ago. As a personal speculative explanation, it may be that permissive Western societies allows all of their citizens, including the psychotic, expression and discharge of muscular and sexual tensions, (i.e. of all tensions contained inward in the body and the mind) through muscular and sexual action. This is in considerable contrast with what was permitted in these countries thirty or more years ago, where such expressions were less accepted by society as a whole. Thus as a result, 30 years ago, dramatic symptoms, symbolic of all-out attempts to psychotically deal with impulsivity, and the impulsive-aggressive-sexual use of the locomotor striated muscles as organs or relation, were not allowed as much, and were therefore more restricted. I believe that this greater liberty in our current climate helps to account for the relative absence of catatonic symptoms in our Western societies. In other countries in the East - China, Japan, India, Schizophrenia Catatonic Type remains currently very prevalent.

The greatest change in diagnostic sub-types is produced by the current diagnostic fashion that results in decrease in Schizophrenia, Schizo-Affective Type. This is caused by the development of lithium as an effective treatment for agitation of moderate severity, but particularly in its utilization as a specific treatment of mania (Bipolar-affective Disorders) and its use as an attempt at prophylactis for Depressive Disorders as well. These two phenomena have induced an increase in the diagnosis of manic illness (Bipolar-affective Disorder) with a concommitant decrease in Schizophrenia, Schizo-Affective Type. My personal view is that this is a diagnostic fad, based on our liking to be therapeutically effective, i.e. that we have "specific therapy" with lithium. It is therefore most fashionable to make the diagnosis of a disease that we can treat. Thus you have a lessening of the diagnosis of Schizophrenia, Schizo-affective Type, not because this category no longer exists, but because it is often linked with manic bipolar illness, not differentiated from it, and thus called by another name.

To sum up briefly, currently in the Western world we see less Hebephrenia, less Catatonia, and although there is plenty of Schizo-Affective Schizophrenia, many of these patients are not called this, but are classified as Bipolar-affective Disorder, and are treated with lithium. It is of course characteristic of the Schizophrenic group of illnesses that a particular patient's symptomatic expression changes over time, so that one subform over time becomes converted to another, i.e. what was Schizo-affective at the beginning might become Paranoid later on, etc.

I have thus, in this short presentation attempted to summarize some aspects of current views of phenomenology, of the

natural course of the illness, of differences in diagnostic views and fashions in the different countries.

References

1. BLEULER,E.: Dementia Praecox and the Group of the Schizophrenias (trans Zinkin, J.) New York: Int Univ Press, 1950
2. BOKOVEN,J.S.: Moral Treatment in Community Mental Health, New York: Springer, pp.61 Table IV, 1972
3. FISH,F.: Schizophrenia, 2nd Edit., Hamilton, M., (Ed.), Bristol, England: J. Wright, 1976.
4. GOLDBERG,S.C., SCHOOLER,N.R., HOGARTY,G.E., ROPER,M.: Prediction of relapse in Schizophrenic outpatients treated by drug and sociotherapy, Arch Gen Psychiatry, 34:171,1977.
5. HOGARTY,G.E., GOLDBERG,S.C., SCHOOLER,N.R., ULRICH,R.F.: Drugs and sociotherapy in the aftercare of schizophrenic patients - 11. Two year relapse rates, Arch Gen Psychiatry, 31:603-608, 1974.
6. HOGARTY,G.E.: Drug and psychological treatment in the aftercare of schizophrenia: A research odyssey, In: Psychopharmaoclogy and Psychotherapy, Greenhill, M.D., Gralnick,A., (Eds.), New York: Free Press, pp. 129-144, 1983.
7. JASPERS,K.: General Psychopathology, (trans., Heonig,J., Hamilton,M.W.), Chicago: Univ of Chicago Press, 1964.
8. KLEIST,K., SCHWAB,H.: Die Verworrensen schizophrenien auf grund katamnestischen untersuchungen. 11 teil Die Denkverwirrten schizophrenien, Arch Psychiat Newvenkr, 184:28, 1950.
9. LANGFLED,G.: The Prognosis in Schizophrenia, Copenhagen: Ejnar Munksgaard, 1956.
10. LEONHARD,K.: Cycloid psychoses - Endogenous psychoses which are neither schizophrenia nor manic depressive, J Ment Sci, 107:633, 1961.
11. LEONHARD,K.: Aufteilung der Endogenen Psychosen Berlin: Akademis, Verl 1968.
12. SARTORIUS,N., JABLENSKY,A., STROMGREN,E., SHAPIRO,R.: Validity and diagnostic concepts across cultures: a preliminary report, In: The Nature of Schizophrenia: New Approaches to Research and Treatment, Wynne, L.C., Cromwell,R.L., Matthysse, S., (eds.), New York: J. Wiley & Sons, pp.657-669, 1978.
13. SARWER-FONER,G.J.: Simon Bolivar Lecture, American Psychiatric Association. Some Thoughts on the Current Status of the Schizophrenia Group of Illnesses: Treatment, Research and Social Aspects. Psychiat J Univ Ottawa, 8:1-16(june),1983.
14. SCHNEIDER,K.: Primary and secondary symptoms in schizophrenia. Fortschr Neurol Psychiatry, 23:487-490, 1957.
15. SOSOWSKY,L.: Explaining the increased arrest rate among mental patients: a cautionary note, Am. J. Psychiatry, 137:1602-1605,1980.

ON REHABILITATIVE TREATMENT OF RESIDUAL SCHIZOPHRENIC PATIENTS - OUTPATIENT AND COMMUNITY THERAPY

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Comprehensiveness is the key to good care for schizophrenic patients in the community. Treatment is directed not only to the removal of symptoms and the prevention of acute relapse but also to an improved quality of life.

Comprehensiveness can be understood as the provision of multiple loci of care: home care, community agency care, outpatient hospital care, day or night care in hospital, supervised residences, cooperative living situations, and institutional care. Ideally, most patients should be given choice in the location of treatment.

Another meaning of comprehensiveness is treatment at all levels: acute emergency treatment, general assessments and re-assessments, check-up visits, psychotherapy. Most patients will require treatment at these various levels throughout life although frequencies will change.

Comprehensiveness also refers to the multiple aspects of life which patients with schizophrenia will need help with. These include careful monitoring of medication to reduce symptoms while, at the same time, keeping side-effects minimal and relapse risk minimal. This is a difficult task which cannot be done without frequent visits and some trial and error attempts at dose adjustment. This needs to be accompanied by education for patient and family about the way drugs work, the relation of dose and individual susceptibility to the alleviation of symptoms and to the development of side-effects. Patients also need instruction on withdrawal effects, toxic effects, and the concept of titrating drug dose to stress.

Besides education about drugs, an important ingredient of the overall program is general education about the disease process, what can be expected, what goals need to be worked toward and what former goals need to be abandonned. This is an area that therapists often neglect for fear of discouraging their patients. Hope for improvement must always be fostered but unrealistic fantasies about return of premorbid functions can be disastrous and can often lead to family arguments and sometimes to self-destructive impulses.

Structure, stimulation, socialization and support are the 4S cornerstones of comprehensive treatment. By structure I mean a daily schedule of activities that have meaning for the patient. Even the most carefully organized daily program will probably not be followed but the following of it is not as important as the knowledge that it exists. I have found it important for patients who are unmotivated and apathetic to know that there is something for them to do every hour of their day, even when they choose not to do it. They are always free, of course, to exercise choice in whether or not to participate. It is infinitely better, however, to decide not to do something than to have nothing about which to decide. In most cases, the scheduling needs to be as detailed as in a children's camp or school, with new activities beginning every hour or so. The activities accompanied by food are more likely to be attended.

Stimulation again refers to not leaving patients alone to do nothing. Coming to the patient who refuses to come out of his room, engaging him or her in conversation or games or encouraging him or her to take part in activities is all part of stimulation. Building in a reward system for participation often produces results. The risk is that over-stimulation may precipitate acute symptoms so that the therapist needs to go slowly and perhaps check out with others (relatives, friends, former therapists) the level of stimulation that an individual usually tolerates.

Socialization is important because intimacy is one of the rewards of life that is not dependent on riches or even on good health. It is an area of special importance to schizophrenics who, for the most part, find intimacy difficult. The difficulty has been described as a need/fear dilemma - a desperate need for others which is frightening in its dimensions. Non-demanding social groups and group activities provide a good forum for socialization. Enduring friendships are often formed even though interactions appear emotionless to outside observers.

Support is essential in all its many meanings. Schizophrenic patients require financial support, help in acquiring proper shelter and food, help in the skills of daily living (shopping, cleaning, budgeting, dressing, cooking, laundering, sewing). They require help in fighting the bureaucracy of mental health programs and legal

help with landlords and others who may take advantage of them. They often need to be rescued from brutalizing friendships or family relations. They may need protection from physical abuse, from unhygienic surroundings and from medical or dental illness. They frequently need help for drug or alcohol addictions and, most of all, from the depression that so frequently accompanies schizophrenia.

A comprehensive program must also provide patients with opportunities for leisure time activities, vacations from the humdrum of their life, educational upgrading, vocational rehabilitation, opportunities for development of creative talents and spiritual pursuits.

A comprehensive program is not useful if it is not used. Services must be accessible. They must be open (at least via telephone) twenty-four hours every day and patients must be able to come when necessary. Transportation services are important. Many patients cannot afford to attend programs because they cannot pay for public transportation. Some patients will never attend anything unless they are actively courted. Successful programs need to incorporate active outreach and home-visiting.

Since most schizophrenic patients now live with their families, rehabilitation programs must focus on the needs of relatives. They, too, need education and support. They, too, need to meet with each other and discuss their common difficulties in order to find common solutions. Families can be taught to interact effectively and therapeutically but they must be treated respectfully and therapists must be prepared to learn from families as well as to teach.

Extremely important is the issue of therapeutic morale. This is a recognized issue for families who become demoralized and irritable. It pertains equally to therapists. The ups and downs of schizophrenic illness provide few rewards for treating personnel. The rewards must be obtained elsewhere - through good salaries, good working conditions, through support and supervision, intensive educational programs, opportunities for teaching, for research and for academic pursuits. The more effort is put into preventing therapists' boredom, frustration and exhaustion, the fewer patients will be victimized for failing to live up to others' unrealistic expectations.

References

Lamb, Richard H: Treating the Long-Term Mentally Ill. Jossey-Bass Publishers, San Francisco, 1982.

Seeman, M.V.: Management of the schizophrenic patient. Can Med Assoc J 120: 1097-1104, 1979.

Seeman, M.V.: Outpatient groups for schizophrenics - ensuring attendance. Can J Psychiatry 26: 32-37, 1981.
Seeman, M.V. and McGee, H.: Treating depression in schizophrenic patients. Am J Psychotherapy 36: 14-22, 1982.
Thornton, J.F., Plummer, E., Seeman, M.V., and Littmann, S.K.: Schizophrenia: Group support for relatives. Can J Psychiatry 26: 341-344, 1981.
Wing, J.K.(ed.): Long-Term Community Care, Psychological Medicine Monograph. Supplement #2, Cambridge, University Press, 1982.

SOCIAL PROBLEMS - ORGANIZING ADEQUATE SERVICES FOR PATIENTS IN THE GROUP OF SCHIZOPHRENIAS

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The Group of the Schizophrenias

Patients afflicted with one of the Group of the Schizophrenias show particular well-known tendencies that express themselves in characteristic symptoms. The natural course of the illness, the "Way of Life". (1) of those chronically afflicted, here takes on a personal individualistic characterological pattern as "the usual way of being" that the patient shows. In its humanistic aspects, the illness thus poses th most profound medical problems for each particular society. The Group of the Schizophrenias poses severe political considerations for each proposed solution in each society, for people with these illnesses. Here again it is a rather complete model of the complexities of what such an illness does to the society in which it exists, and of what a particular society does to people with an illness. If one looks at the particular social dependency needs of people with Schizophrenia in its severe forms, then the interactions between these forms and the demand that the symptomatic expression of these forms makes on the social organization of a particular culture and society, also offers interesting food for thought. Here it poses the issue of how much money and resources a society will put into people with such illness, and what the needed range and spectrum of such resources should be, or are. I have discussed these more fully in my Simon Bolivar lecture, (3) and space and time does not permit me to elaborate on these today.

Today, in the 1980's, as compared to almost double these figures 30 years ago, less than 25% of all beds are psychiatric in developed Western countries, and less than 12.5% of these beds are occupied by patients with Schizophrenic illnesses. Instead,

massive numbers of such patients are now out of hospital in non-medical welfare facilities, hotels, boarding houses, group homes, jails (4) and penitentiaries. What are the implications of these facts? Governments around the world use various planning figures to determine the range of medical facilities. In Canada and the United States, a planning figure of 4-5 beds per thousand of the population for general hospital beds, (not for psychiatry) is often used. Currently in Ontario, Canada, the figure of 3.5 beds/thousand is being used in some cities, and there is a shortage of beds for some categories at this figure. For the needs of acute psychiatric patients, usually in general hospital psychiatric units, a planning figure of 0.45 beds per thousand was to be added to the above mentioned figure, and a planning figure of 0.8 beds per thousand for chronic psychiatric patients was added to these figures. Often, another planning figure of 1-1.5 beds per thousand for Geriatric Medicine (not psychiatry, but geriatric medicine) was also added. To understand the meaning of these figures, it is important to note that where general hospital psychiatric units are available, the number of Schizophrenic patients hospitalized in these units vary from 12-22% of all psychiatric admissions to these units. The nature of this variance is determined in the communities concerned, by the differences in availability of other than general hospital based acute emergency admission facilities such as, in state mental hospitals or other emergency facilities, as well as the existance of adequate facilities for hospitalizing chronic or psychogeriatric patients. Where such facilities do not exist, more patients with Schizophrenia are admitted to the acute general hospital psychiatric units for a maximum of roughly 22% of all admissions. With these social planning and policy figures and thoughts as a background, let us briefly look at the issues of current (1983) therapy for the Schizophrenias and its non-specific curative nature.

The therapeutic specificity offered by a good anaesthetic in its capacity to put somebody to sleep safely and reliably, offers what I call "a good model of treatment specificity". (2) Here if you use the anesthetic properly, the patient will go to sleep safely. In this context it does not matter whether you know the psychodynamics of the patient's life, whether he/she had a fight with spouse, whether he/she is happy, unhappy, etc. Such factors may influence dosage, you may need a little more of the anaesthetic if a patient is particularly anxious, etc. - but this will not change the therapeutic specificity of the treatment in its fundamental sense. Similarily, if you give an adequate dose of Penicillin for a Penicillin sensitive disease like "Yaws", the Penicillin will cure the yaws. Again it will do this whether the patient being treated had a fight with its brother-in-law, hates his mother or father, etc., it will still cure the yaws. Using such specific therapy gives us an opportunity for the proper use of what I have called "a good public health model for treating

sensitive-to-cure diseases", a physician makes an accurate diagnosis, then the treatment can be applied by any physician, or a non-physician trained liaison person, working, as part of the medical team (under medical aegis) attempting to treat or wipe out that disease. For example, in such a public health effort to wipe out Yaws, or Smallpox, one can teach technicians to give an injection of penicillin for the Yaws, or vaccination for the smallpox, provided the physician has made the correct diagnosis of the disease, or has correctly indicated the need for the vaccination. Here, specific curative or preventative therapy can lead to economies in medical manpower, and eliminates the need to know the psychodynamics, the family life, and social situation of the patient. Even though knowing such things may be generally desirable, not knowing them does not negate the specific treatment.

In view of the above considerations what the realities as to the status of current psychotropic drug therapies in Psychiatry, and in particular of the neuroleptic treatment of the Group of the Schizophrenias? Well, we have drugs with a reliable clinical effect when given in adequate dosage (what I have called "the particular pharmcological profile of the drug concerned"). Unfortunately, this clinically reliable, specific pharmacological profile visible in all patients to whom it is given in adequate dosage, (with or without individual idiosyncrasy), is therapeutically (ie curatively) non-specific. It does not cure the disease - Schizophrenia. Its global over all actions do covary generally on statistical on statistical analysis of covariancy, with some aspects of global improvement in some of the symptomatology of patients with Schizophrenia ("productive" or "action" symptoms) but unfortunately the disease as such is not cured by the present (1983) availability at our current level of knowledge of neuro-leptic therapeutic agents.

In terms of public policy in most countries however, our planners unfortunately behave as though we do have specific curative therapy for Schizophrenia, and this, in a reality situation, where regrettably we do not have specifically curative treatment. We thus erroneously behave as though the same techniques that can be used for my, "good public health models for curative or preventative treatment for specifically curable diseases" (eg yaws or vaccination for small pox), can be used to treat diseases such as Schizophrenia, for whom regrettably we do not currently have specifically curative therapy.

Le us now examine some of the implications of this approach. Believing, erroneously, that we can use models for Schizophrenia, that apply to diseases that are curable with our current therapies, governments and planning authorities often behave as though their country does not need considerable numbers of physicians, medical specialists for these tasks, and therefore that you do not need

psychiatric physicians for these tasks. Secondly, they behave as though all that is needed is "a physician" to make an adequate diagnosis and then they often behave as though other non-medical technicians can treat the illness, and if this is done Schizophrenia will "go away". They thus behave as though a country can save money on training doctors, and as though such a country does not need these medical specialist-psychiatrists - in any numbers, nor does such a country need (in this view) long term treatment facilities, etc. What however is the reality of such views? The reality is that we do not have specifically curative measures, that eliminate the disease Schizophrenia, and yet many behave as though we do.

The fact is that we do not have specifically curative therapy. In 1983, the neuroleptic drug treatments are crucial and useful. They help many patients, but in many cases we cannot claim that this therapy is curative of the Schizophrenia. Given this reality, we need a full range and gamut of all the facilities needed to treat Schizophrenic patients, this inclused the rehabilitative chronic, long-term facilities including some hospital beds for the hard core of such patients (relatively small in number) who will do better if they live their life in a good hospital for such an illness than if discharged out of the hospital to rehabilitative facilities. We need good rehabilitative centers under medical control, or a good relationship to a medical aegis. We need good collaboration under medical aegis with special services agencies, such as employment agencies, sheltered workshops, half-way houses, group living homes, etc., for the rehabilitation of those chronic patients that can do better in the community and out of a chronic institution.

The absence of specific curative therapy makes the teaching of all we know about the psychodynamics of the illness, the human aspects of the disease, of Schizophrenia as "a way of life"(1,2,3) and of the defensive use of psychotic characterologic defenses by Schizophrenic patients, essential. We have to teach about the coping, feeling aspects of schizophrenic patients and how to cope and treat these aspects. All of the above must be demonstrated and taught to our medical students, to our residents in psychiatry, by sophisticated psychiatric specialist-physicians who have large experience with these cases, and who can teach and demonstrate such material, to psychiatric residents, to medical students, to general physicians and to the allied health and professionals and medical auxiliary who will work as part of medical teams in the treatment and rehabilitation of these patients.

Above all, we need new research models which will try to get at the physiologic mechanisms ofsome of the humanistic aspects of the thinking and feeling of Schizophrenic patients. This would have to be "married up" with the increased knowledge of biochemistry

and the basic biological phenomena which are the subject matter of some of my colleagues' presentations today, and which I have summarized in my Simon Bolivar lecture (3) more fully but cannot offer here.

The need for a proper gamut, range, or spectrum of psychiatric services to properly treat and care for complex psychiatric illnesses runs into many boundaries each of which has to be transcended if action to obtain the needed facilities is to ensue.

References

1. HILL,L.B.: The nature of extra mural schizophrenia, In: Schizophrenia in Psychoanalytic Office Practice, Rifkin,A.H., (Ed.), New York: Grune and Stratton, 1957.
2. SARWER-FONER,G.J.: Schizophrenia 1980: Implications for Psychopharmacology. Ch. 7, pp 67-83 in Psychiatry, Psychopharmacology and Alternative therapies: Trends for the 80s. Schwab,J.J., Edit., New York, Marcel Dekker,1981.
3. SARWER-FONER,G.J., The Simon Bolivar Lecture, American Psychiatric Association. Some Thoughts on the Current Status of the Schizophrenic Group of Illnesses: Treatment, Research and Social Aspects. The Psychiat J Univ Ottawa, 8:1-16(June) 1983.
4. SOSOWSKY,L.: Explaining the increased arrest rate among mental patients: a cautionary note. Am J Psychiatry, 137:1602-1605, 1980.

"NORMAL DEVIANCE" - CHANGING NORMS UNDER ABNORMAL CIRCUMSTANCES

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One of the strategies widely used in family research consists of comparing families containing a schizophrenic offspring with families in which no psychiatric disorder occurs. Whereas the first group is considered "abnormal", "pathologic" or even "pathogenic" the second is used as a "normal" control. Differences observed between both groups are seen as indications of familial abnormalities which presumably either preceded the onset of the disorder or appeared subsequently in reaction to it. The first interpretation all too readily ignores that these families are exposed to one of the most devastating and catastrophic events that they can experience. And not only family researchers are prone to this scotoma. If you take, for example, one of the most elaborate interview schedules of stressful life events, you will find virtually every major event concievable in an individual's life but you will miss the fact that a close relative had become mentally ill. The alternative interpretation which focuses on the impact of the psychiatric illness on the family shares one problem with the first interpretation. It overemphasizes the pathologic aspect which considers differences in interaction patterns between index and control families almost automatically as abnormalities and deviances. Both views tend to neglect that the standard norms that used to govern family life might have become obsolete and that new norms have emerged that may prove to be more appropriate. Behavioral styles, attitudes, interactional modes under normal conditions considered deviant or abnormal may in fact indicate a successful adaptation to the new situation. And the reverse might also be true although it may at first glance appear somewhat paradoxical, namely that behavior usually defined as "normal" could be an indication of insufficient adaptation and therefore "a-normal".

Two studies on the association between family environment and the course of schizophrenia, both using direct observation techniques, do in fact suggest that this could be the case. Let us first look at some results of a study my colleagues and I conducted in Hannover. In this study all families from the Hannover area were included wherein a son, 15 - 30 years old, was admitted to psychiatric inpatient treatment for the first time in his life, and where both natural parents were still living together as a married couple. The diagnosis was based on the Present State Examination[1], only patients who displayed at least 6 signs and symptoms which, according to Carpenter et al.[2], best discriminate schizophrenia from other psychiatric disorders were included. 30 families were studied which represents 77% of all families eligible during the study period of 2 ½ years. The contrast group consisted of 30 families with sons who had been admitted to surgical units of two hospitals in Hannover with acute abdominal conditions or who required plastic or accident surgery. Neither the patient nor the parents were stated to have previously required psychiatric help.

At the time of discharge of the patient, each family, i.e. the son plus both parents, were invited to a joint discussion of problems of daily family life which was stimulated by means of Strodtbeck's[3] revealed differences technique. The discussions were recorded on audio- and videotape and verbatim transcripts of the former provide the source of data for this report. For the assessment of the emotional atmosphere in the families we used the Content Analysis Scales developed by Gottschalk et al.[4] which allow a detailed quantitative analysis of two emotional qualities, hostility and anxiety, which in view of the literature could be relevant to the course of schizophrenic illness. Two years after discharge from the first inpatient treatment each family with a schizophrenic patient was contacted again. In about half the cases (n=13) the patient had been readmitted to the hospital and in half not (n=17). Both groups did not differ significantly in any of the psychiatric and sociodemographic variables that we had assessed (more details can be found in Angermeyer[5]).

In the following section I will compare some of the results obtained from both subgroups of families with schizophrenic patients and the group of families with organically ill patients. My focus will be exclusively on the domain of hostility. As expected from the work of the research group at MRC Social Psychiatry Unit in London, fathers of readmitted schizophrenic patients verbalize more openly in a more outwardly directed hostile manner than fathers of schizophrenic patients who were not readmitted (Tab.1). They also project more hostile impulses onto others ("ambivalent hostility"). By contrast, mothers of readmitted schizophrenic sons show more autoaggressive and intrapunitive tendencies than those of schizophrenic patients not readmitted. According to psychodynamic theories, this could be considered one of the determinants of overprotective

Table 1. Hostility scale: Analysis of variance, Scheffé-test (means)

	RS[a]	NRS[b]	OI[c]	RS vs. NRS	NRS vs. OI	RS vs. OI
Fathers:						
Hostility directed outward overt	1.53	1.15	1.15	x	-	x
Hostility directed outward covert	1.56	1.77	1.53	-	-	-
Hostility directed inward	0.49	0.49	0.52	-	-	-
Ambivalent hostility	0.57	0.40	0.54	x	-	-
Mothers:						
Hostility directed outward overt	1.30	1.53	1.13	-	x	-
Hostility directed outward covert	1.61	1.82	1.52	-	-	-
Hostility directed inward	0.79	0.56	0.59	x	-	x
Ambivalent hostility	0.69	0.59	0.48	-	-	x

Table 2. Hostility scale: Pearson-correlations for all 3 days

	Fathers &			Mothers &			Fathers & Mothers of		
	RS[a]	NRS[b]	OI[c]	RS	NRS	OI	RS	NRS	OI
Hostility directed outward overt	-	-	-	$.55^{x}$	-	-	$.68^{xx}$	-	$.52^{xx}$
Hostility directed outward covert	$.60^{x}$	-	$.59^{xx}$	-	-	$.40^{x}$	$.61^{x}$	-	$.57^{xx}$
Hostility directed inward	-	-	-	-	-	-	-	$.48^{x}$	-
Ambivalent hostility	-	-	-	-	$.66^{x}$	-	-	-	-

[a] readmitted schizophrenics [b] not readmitted schizophrenics [c] organically ill [x] $p < .05$ [xx] $p < .01$

behavior and emotional overinvolvement reported by other researchers. In addition, among the parents of the contrast group the fathers of rehospitalized schizophrenic patients also express more overt hostility than fathers in the contrast group, and for mothers the same is true regarding autoaggressive tendencies. Or in other words: In both cases it is the group with an unfavorable outcome of schizophrenia that proved to be "abnormal". In other instances the picture is less clear and it is, for example, only the mothers of schizophrenic patients not rehospitalized who express a significantly higher amount of hostility against others. But taken together the results presented as yet do not seem to lend much support to the hypothesis stated in the beginning.

Let us now turn to the relationship between the mean affect scores of the three family members who participated in the discussion (again, the whole discussion time being the unit of analysis). As we can see from Table 2, in all three dyads - father-son, mother-son, and both parents - the same pattern emerges: Only in the group with readmitted schizophrenic sons and in the contrast group can statistically significant correlations in the domain of outside directed hostility be found. This is not the case in the group with schizophrenic patients not readmitted where some relations in the area of autoaggression or projected aggression seem to exist. As discussed in the beginning, it is in fact only in the families containing schizophrenic patients who have an unfavorable institutional career that "normal" relationships do prevail whereas families with patients with a better outlook "deviate" from the common standard norm. This suggests that the rather detached relationships (which allude to some aspects of the concept of low "Expressed Emotion") observed in families with patients who are not readmitted may indicate the successful adjustment to the new situation.

Similar results yield the analyses of the dynamics of the emotional interplays during the course of family discussions (based on the mean values for hostility scores for each 5-minute segment). As Figures 1 and 2 show for the subtypes of outwardly directed hostility, the profiles of mothers and sons are rather parallel in both, families with rehospitalized schizophrenic patients as well as the contrast group (suggesting a symmetrical relationship). By contrast, in families with schizophrenic patients not readmitted the scores of the mothers on the hostility scales always drop to their lowest value whenever the scores for the sons reach their highest value (suggesting a more complementary relationship). What is suggested by plain inspection of the tables can also be demonstrated statistically using a multivariate trend analysis for repeated measurements with orthogonal polynomial transformations as given in the MANOVA procedure in SPSS[6]. Only in the case of families with schizophrenic patients who are not rehospitalized can statistically significant differences between the profiles of mother and son be obtained. Analogous findings revealed also the

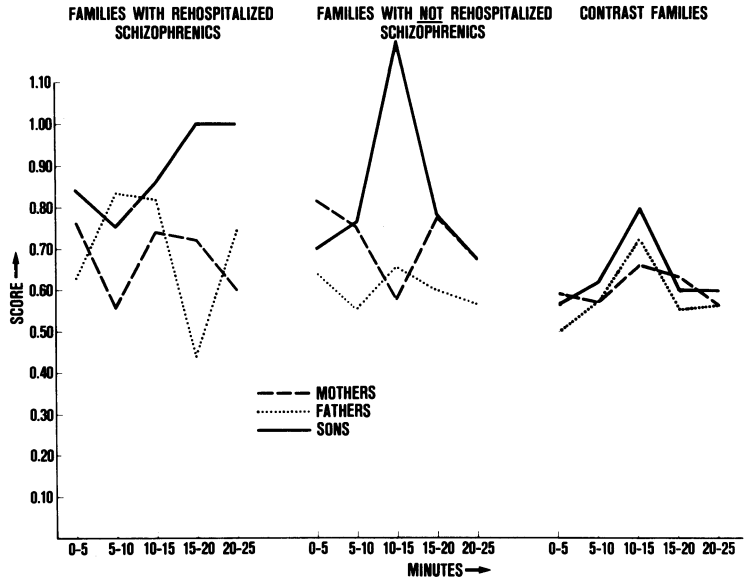

Fig. 1. Profiles of mean values for each 5-minute segment: Hostility directed outward overt

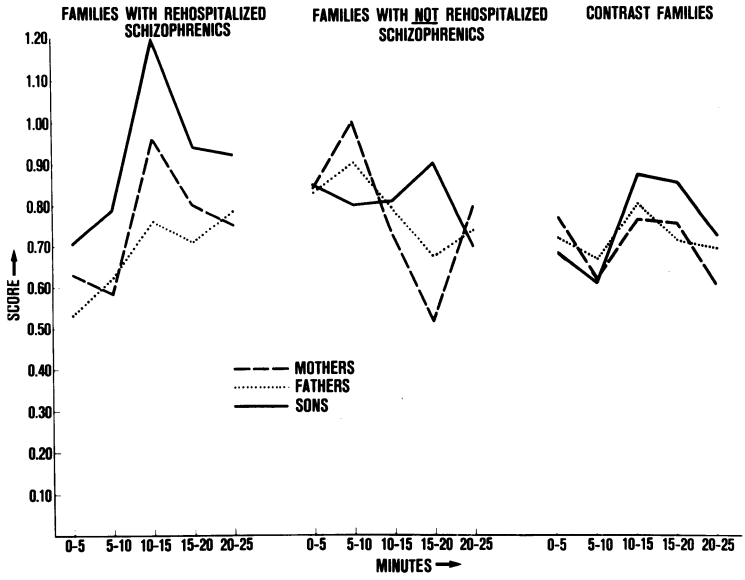

Fig. 2. Profiles of mean values for each 5-minute segment: Hostility directed outward covert

analysis of the other two types of hostility. Again, it is the families containing schizophrenic patients with better prognosis that deviate from the common norm.

As already mentioned another study also using direct observation techniques points to the same direction. I am referring to the work of Francis Cheek - an almost forgotten pioneer in this field. In a paper published in 1965 Cheek[7] reports the investigation of interaction patterns in families with schizophrenic patients of both sexes and "normal" control families. She had analyzed family discussions which also had been generated by means of Strodtbeck's procedure, using a modified version of Bales' Interaction Process Analysis. At a 1-year follow-up the convalescent adjustment had been re-assessed. Summarizing her results Cheek states: "Apparently the more 'normal' the family on most of the characteristics which differentiate between families of 'normals' and 'schizophrenics', the worse the outcome of the schizophrenic...Our study has revealed a characteristic distortion of the family environment of the schizophrenic, a distortion of parental attitudes and role behavior, which shows up most notably in the area of techniques of social control. In the absence of certain aspects of this distortion the convalescent schizophrenic deteriorates. This suggests that the distortion might serve a useful function for the schizophrenic." (p. 145)

Preliminary and rather serendipitous as these results may be, they at least suggest that in families with schizophrenic patients the functional norm is submitted to change. Interaction patterns, usually considered as dysfunctional or deviant, prove now to be functional, hence normal. This should lead us to re-examine our own implicit or explicit notions of a "normal family". I think this could help us to better tolerate previously assumed deviance and would make us hesitate more often from calling families "abnormal", "pathologic" or even "pathogenic". This in turn might even help families to cope better with schizophrenic illness.

References

1. Wing,J.K., Cooper,J.E., and Sartorius,N., "The measurement and classification of psychiatric symptoms," Cambridge University Press, Cambridge (1974)
2. Carpenter, W.T., Straus, J.S., and Bartko, J.J., Flexible system for the diagnosis of schizophrenia: Report from the WHO International Pilot Study of Schizophrenia, Science 182:1275 (1973)
3. Strodtbeck, F.L., Husband-wife interaction over revealed differences. Am.Sociol.Rev. 16:468 (1951)
4. Gottschalk, L.A., Winget, C.N., and Gleser, G.C., "Manual of instructions for using the Gottschalk-Gleser Content Analysis Scales," California Press, Berkeley (1969)

5. Angermeyer, M.C., The association between family atmosphere and hospital career of schizophrenic patients, Brit.J.Psychiat. 141:1 (1982)
6. Hull, C.H., and Nie, N.H., "SPSS Update 7-9," Mc Graw-Hill Book Comp., New York (1981)
7. Cheek, F.E., Family interaction patterns and convalescent adjustment of the schizophrenic, Arch.Gen.Psychiat. 13:138 (1965)

BEHAVIOURAL FAMILY THERAPY FOR SCHIZOPHRENIA:

A CONTROLLED TWO-YEAR STUDY

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INTRODUCTION

Behavioural family therapy in the treatment of adult mental illness has developed since 1970. In addition to its use in the management of schizophrenia and depression, it has been employed in most areas of psychopathology, such as mental retardation, anorexia nervosa, anxiety disorders, substance abuse, children's problems, and in the management of diabetes and coronary artery disease. In other words, the approach is generic.

In common with most of the conditions cited above, schizophrenia is considered to be a biological disorder mediated by environmental stress. Sources of environmental stress are multi-determined, and the impact of that stress highly individualized. Therefore, in order to apply effective stress management, a comprehensive functional analysis of the current and potential sources of stress confronting each person is essential. This includes considerations of both biological and psychosocial systems, and an assessment of the capacity of the individual to cope with stresses. It is assumed that each person is functioning at his or her optimal coping capacity when attempting to handle any undesirable environmental stress. Thus, a detailed analysis of the strengths and weaknesses of that person's coping functions is the baseline upon which more effective strategies may be sought.

As well as being a potential source of environmental stress, the family is the greatest natural resource for buffering the impact of stress upon its individual members. For the family unit to function effectively in this role each family member's

strengths and weaknesses in handling their own stresses, including those imposed by other members of the household, must not exceed their maximum coping potential. As the "expressed emotion" research has indicated, that where only one member of a household is unable to cope effectively with the problems of a functionally-disabled member (Vaughn and Leff, 1976), or when a major life-event overwhelms the family unit as a whole (Leff and Vaughn, 1980), an exacerbation of symptoms in the vulnerable family members is likely. This risk of exacerbation can be modified in schizophrenia through reducing the biological vulnerability of the person with an established illness through the use of prophylactic neuroleptic drug therapy. However, this latter strategy is not without its own potential to produce stress through unwanted effects, and any method that can reduce the need for long-term drug therapy is highly desirable.

The behavioural family therapy approach has been clearly documented (Falloon, et al, 1984). To summarize, the main feature is an attempt to improve the efficacy of family problem solving by increasing the frequency of distraction-free discussions between family members in the home environment, and enhancing the efficiency of problem solving through increased structure. Families are encouraged to use a six-step structure in problem solving discussions. These steps involve 1) identifying a specific problem, issue or goal; 2) listing a wide range of both "good" and bad solutions in a non-judgemental manner; 3) evaluating the advantages and disadvantages of each proposed solution; 4) agreeing upon the optimal strategy; 5) detailed planning of implementation of that strategy; 6) implementing the plan and evaluation of its effectiveness. Families are taught this stepwise approach through oral and written instructions with therapist modelling and coaching. After several workshop sessions, most families can apply the approach unassisted by the therapist, who encourages them to use the strategy whenever a problem arises at home or a family member seeks advice about achieving a personal goal, or shows concern about any aspect of his or her life.

This approach enables the family to find their own creative solutions to problems and to conduct their own on-going functional analysis. However, in most families who are burdened with the stress of a disabled member (whatever the disorder), the ability to communicate their feelings clearly and freely is impeded, and problem solving discussions are either avoided, for fear of the consequences of an outpouring of pent-up emotions, or tend to be characterized by vague, somewhat tangential discussions of the major issues. In such families these communication difficulties must be adequately addressed before problem solving can be enhanced. The expression of negative and positive feelings in a specific manner, that leads to open, clear and constructive problem solving is encouraged. Improved emotional and cognitive

communication is crucial where it is a major impediment in family problem-solving. Outside a problem-solving framework training improved communcation appears to have limited relevance. Unlike family interventions that seek to reduce the level of expression of emotions, this method aims for increased expressiveness, albeit in a problem-solving context. At times complex family transactions may impede effective problem-solving and methods similar to those employed in other family therapy approaches are used.

A CONTROLLED TRIAL

The effectiveness of behavioural family therapy (BFT) was compared with individual supportive therapy (IST) in persons who returned to live in stressful family households after a clearly defined episode of schizophrenia. The aims of both treatment methods were to maximise the social functioning of the index patients and their families, while minimizing functionally disabling psychopathology over a two-year period. A broad range of services were provided in addition to the core interventions; they included, comprehensive crisis intervention and case-management, that involved continuous care throughout the two years regardless of hospital admissions or exacerbations, and psychosocial rehabilitation counselling.

Patients with schizophrenia as defined by PSE/CATEGO and DSM III criteria, who were living in high-stress households, according to the "expressed emotion" index and/or overwhelming family burden, were randomly assigned to BFT or ISP after they had been stabilized at home on the minimal dosage of neuroleptic medication to maintain florid symptom stability. Prescribing pharmacologists were unaware of the psychosocial treatment each patient was receiving and continuously adjusted the dosage of neuroleptics to meet the changing vulnerability/stress diatheses of patients over the two years.

ISP was designed as the optimal procedure for the individual management of schizophrenia. It was a problem-oriented approach that focused on the optimal community functioning of the index patient. Support for families was provided in all cases, but this took the form of meetings with relatives on an ad hoc basis, advice on patient management, and assistance at times of crisis. No systematic family problem-solving that involved index patient and family in conjoint discussions was provided. Home visits were made when necessary, but treatment was clinic-based. All family sessions were held at home during the first 9 months. Sessions of one-hour duration were conducted on a weekly basis for three months for both conditions, after which they were tapered to bi-weekly until nine months, and monthly thereafter. The same therapists treated an equal number of patients in each condition. Thus, the intensity of treatment and therapist

variables were controlled, but the location of treatment was not.

RESULTS

Detailed presentation of the results is found in a number of other publications (Falloon et al., 1982; Falloon, 1984). A brief synopsis is provided here. Thirty-six patients and their families completed 9 months of treatment and were followed up at 24 months, with complete data on 34.

Clinical measures: ISP patients (n=18) suffered 21 major exacerbations of schizophrenia, and were clinically unstable for 4 of the first 9 months. BFT patients (n=18) suffered only 3 major exacerbations and were clinically unstable, with symptoms of any kind, for 2 months out of the first 9. This tendency for less stability in ISP was evident on blindly-rated rating scale measures of target symptoms and the BPRS Thought Disorder factor. 50 per cent of ISP patients were admitted to hospital compared with 11 per cent of BFT. The BFT patients continued to remain stable over the entire two years, whereas the course of ISP continued to show considerable instability.

Social functioning: Measures of social functioning showed a consistent superiority for family therapy. At the end of two years 41% of BFT patients were free of any functional social impairment, while only one (6%) of ISP cases had achieved this status.

Family status: BFT resulted in substantial reductions in the burden associated with caring for the index patient. Smaller benefits were noted after two years in ISP families. Evidence of significant changes in family problem solving and coping behaviour appeared associated with clinical, social and family benefits.

Economic analysis: This revealed a saving of 20% on the basic cost of community care associated with the family approach during the first year of the programme, with further savings accruing in the second year.

CONCLUSIONS

This study provides evidence of the efficacy of behavioural family therapy as a major component of a community programme for the management of schizophrenia. Despite substantial gains in social status, clinical stability was maintained, and family burden was reduced. This added effectiveness was achieved at a lower cost than an individual management approach.

REFERENCES

Falloon, I.R.H., Boyd, J.L., McGill, C.W., Razani, J., Moss, H.B. and Gilderman, A.M., 1982, Family management in the prevention of exacerbations of schizophrenia: a controlled study, N. Eng. J. Med., 306:1437.

Falloon, I.R.H., 1984, "Family Management of Mental Illness: A Study of Clinical, Social, and Family Benefits," Johns Hopkins University Press, Baltimore.

Falloon, I.R.H., Boyd, J.L. and McGill, C.W., 1984, "Behavioural Family Management: Enhancing Family Coping with the Care of the Mentally Ill," Guilford Press, New York.

Leff, J.P., and Vaughn, C.E., 1980, The interaction of life events and relative's expressed emotion in schizophrenia and depressed neurosis, Br. J. Psychiatry, 136:146.

Vaughn, C.E., and Leff, J.P., 1976, The influence of family and social factors on the course of psychiatric illness: a comparison of schizophrenic and depressed neurotic patients, Br. J. Psychiatry, 129:125.

HELPING THE FAMILY TO COPE WITH SCHIZOPHRENIA: PROFESSIONALLY SUPPORTED SELF-HELP

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INTRODUCTION

This is a joint presentation by a psychiatrist (H.K.), a psychologist (T.K.) and a relative (P.S.). It contains observations on the work carried out over the last years in the framework of a self-help organization where relatives of psychiatric, mainly schizophrenic patients, help each other and are helped by professionals.

The purpose of this paper is to present professionally supported self-help for relatives as both a humane and economical model for managing schizophrenia in the community. We will begin by describing the historical development and present activities of the Viennese self-help organization. We will then present some data of a recent survey carried out on the group and finally outline the basic philosophy of professionally supported self-help for relatives of schizophrenic patients.

THE VIENNESE EXAMPLE

The motives for creating a self-help organization of relatives in Vienna go back to the senior author's experiences with the "National Schizophrenia Fellowship", a self-help organization of relatives and friends of sufferers form schiziphrenia in Great Britain. In 1976/77, when the senior author returned from England to Vienna, one of the authors' of this paper (P.S.), whom he had known before on a private basis, had suddenly become a relative. This was to become the start of a professionally supported self-help organization which today has several hundred members, friends and supporters.

In the beginning the idea of founding an organization did not receive much response from the relatives approached. It turned out that most of them were overburdened, hopeless, had no time, and regarded this extra activity as something beyond the scope of their practical living arrangements. However, a small group of about ten relatives started to meet regularily to tell each other their history and problems, to exchange information about practical aspects of managing their difficult situation, and to help one another in many other practical ways.

At the beginning all relatives were very anxious not to declare themselves publicly. Professional support was necessary, not only on a counselling basis concerning psychiatric problems, but also on an organizational level. A telephone number, which was made available to provide other relatives with the possibility of contacting the group, was not that of a relative, but the number of an institute, where a secretary filtered the incoming calls. Only then were contacts between "new" relatives and members of the group established.

After one year of being together, a formal association was founded in 1977/78, called "HPE" (Hilfe für psychisch Erkrankte = help for those who have become mentally ill).

A monthly "jour fixe" was established, which usually started with the "new" relatives reporting about their problems and discussing them with the "old" relatives, and which finished with a short lecture by an invited professional with subsequent discussion. A newsletter (called "KONTAKT") was issued, containing announcements about the "jour fixe", letters from relatives, practical information, book reviews, etc.

The foundation of a formal organization also marks the beginning of an increase in members of the self-help organization. One possible reason for this growth was that not only formal members of the association but also relatives who were "just interested" were accepted as participants in the activities. This gave the chance to many of establishing more or less constant contacts with other relatives without having to indentify completely with the organization.

Two years after the official start of the association, more than 150 people were on its mailing list and up to 30, 40 or 50 turned up for the monthly "jour fixe". The senior author had built up a small group of professionals - other doctors, social workers and legal experts - who were willing to give help on an individual and on a group level whenever necessary.

Furthermore, the group decided to ask the most important psychiatric professionals in Austria whether they would be willing

to be part of a professional board for the self-help organization. All of them agreed, and the names of these professionals were put on the front page of the newsletter, thus documenting that the self-help organization was accepted by and had contact with the professional world. While most relatives accepted this measure, doubts were raised as to whether that did not mean too strong an identification with the existing psychiatric system.

At this stage of development the association started to increase its public activities. Relatives discussed issues of psychiatric care on radio and television, influenced newspapers and contacted politicians; conferences were organized which were even attended by the President of the Republic; a formal address at the home of one relative was established; and the organization found shelter in a community center with some alternative touch.

One day, after the senior author had given a lecture on schizophrenia, some relatives approached him with the wish to organize a group in order work through their "psychological problems". Out of this demand a regular program of "sensitivity groups" for relatives run by a psychiatrist and a psychologist was established. Among the most common problems discussed in these groups are feelings of guilt, exhaustion due to being overburdened, overdevotedness, problems with psychiatrists, and uncertainty how to treat the patient adequately.

RESULTS OF A SURVEY CARRIED OUT ON RELATIVES OF THE SELF-HELP ORGANIZATION

In a recent postal survey 105 questionnaires out of 286 sent out to members and friends of the self-help organization were returned. 79 of these could be analyzed (Table 1). Those who responded to the survey probably constitute a particularily selected group of relatives who identify with the aims of the self-help organization. This fact is underlined by the rather high percentage of relatives eager for contacts with psychiatrists of politicians responsible for the health care system, by the rather low frequency of relatives having feelings of guilt, and by a less positive attitude towards psychiatrists. The majority of relatives complain that the doctors have too little time for them and wish more opportunities to discuss illness and treatment. Some of them would like to have lay-helpers in order to alleviate the problem of caring for the patient. Most relevant seems to be the desire to create hostels for patients where they may be cared for in a human environment and which are not too far away from home. The last wish suggests that the core of the self-help organization of the relatives has a quite realistic and not overengaged attitude, being prepared to let the sick family member go his own way while at the same time being concerned with his destiny.

Table 1: Selected results of a questionnaire survey among the members of the Viennese self-help organization (HPE) (N = 79)

What are you especially interested in?

Interested in discussions with psychiatrists	63,3%
Interested in discussions with politicians	39,2%

What do you find especially useful in HPE?

Information about disease and therapy	68,4%
Exchange of experience	69,6%
Practical help	32,9%
Newsletter	49,4%

Have you already participated in "sensitivity groups"?

With professional	69,6%
Without professional	17,7%

Are psychiatric ambulatory services suffiecient?

yes	10%	no	73,4%	don't know	16.6%

Mostly good experiences with professionals?

With psychiatrists	25,0%
With nurses	32,0%
With psychologists	39,0%
With social workers	48,0%

What are your main problems?

	never	sometimes	always
Future patient	4,2%	19,5%	76,4%
Restriction in leisure time	25,8%	37,9%	36,4%
Uncertainty how to react to patient	14,1%	69,0%	16,7%
Feelings of guilt	52,4%	39,7%	7,9%
Additional household duties	36,2%	25,9%	37,9%
Financial problems	54,6%	30,9%	14,6%

These relatives are obviously prepared to take up the role of an active, albeit partly militant praticipant in a comprehensive care system where they claim an important role.

THE PHILOSOPHY OF PROFESSIONALLY SUPPORTED SELF-HELP

The basic philosophy of the self-help organization is that a relative should take over a new and active role in the care of the patient.

Relatives of psychiatric patients have so far played at least four different roles, as seen by psyichiatrists. Historically the first two roles were that of a research object in genetic studies and of an informant for professionals about the patient during treatment (Table 2).

Table 2: The roles of the relative of the psychiatric patient as seen by psychiatrists

(1) Object of genetic studies
(2) Informant about patient's illness during treatment
(3) Cause of the patient's illness
(4) Victim of the patient's illness

Some thirty years ago the interest of several authors started to center around the role of the family in the causation of mental illness. No doubt the role of a victimizer creates feelings of guilt and it is difficult to assume.

The fourth role, that of the relative as a "victim" of mental illness, was "discoverd" in the late sixties, when social psychiatrists started to identify all kinds of burdens on the family which had arisen as a consequence of the discharge of large numbers of patients into the community.

Relatives who are members of the Viennese self-help organiszation are aware of all these roles which relatives may play. In principle, they can accept all these roles. In addtion, however, they are self-confident, have become emotionally and intellectually independent, and have developed a growing self-help potential. They are aware of the fact that it is them who may provide the highest quality of life for the patient, but they also know that the social network of the family may not only be a "safety net", but also a "spider web" in which the patient can get enmeshed.

But what is the role of the expert in such new, active, and self-confident understanding of the relative's role? It should be clear that the role of experts in the self-help organization has never been to treat individual patients, but to strenghten the ability of the organization to survive in the face of many threats.

The functions of experts in a self-help organization are

manifold:

(a) The most obvious role of the professional in such a self-help organization is that of providing adequate information about those areas where such information exists. In this respect the role of the expert is twofold: providing available information and making it clear to the relatives where the boundaries of today's psychiatry lie.

(b) A more subtle reason for cooperation with experts is that relatives can "work through" the problems they usually have with professionals in a kind of "role playing".

(c) "Showing" that experts are with them helps the relatives to be taken seriously by both politicians and psychiatric experts.

(d) The experts who work with relatives can be understood as "outposts" of the professional system who gain new experiences the professional system was never before able to obtain and who can pass what they learn on the their colleagues.

(e) They can warn the organization before it becomes secterian (such as becoming an adherent of vitamin deficiency theory of schizophrenia).

CONCLUSION

Relatives and experts both have specific roles to play in the provision of care to the more severely handicapped psychiatric patients. Both have their own type of responsibility and they should be able to share this responsibility in a reasonable way. For the relative, living as victimizer and living as victim is no fun. A merciless family theory accuses the relatives; a merciful social psychiatry tries to replace the family. Both, albeit for different reasons, try to separate the family members. However, for the patient as well as his relatives such a separation may prove worse than to continue living together.

We contend, that for the more severely handicapped psychiatric patient, staying in constant contact or living together with a relative is in most cases better than staying alone or in institutions. Enduring and meaningful social contacts in a social network which cares for its members on a lifelong basis whenever available seem to be more humane than help in institutions or letting a severely disabled patient alone. There is no doubt that families will not be able to do this without help

from each other and from the professionals.

REFERENCES

Katschnig, H. (Ed.): Die andere Seite der Schizophrenie - Patienten zu Hause. Urban & Schwarzenberg, München Wien Baltimore, 2. Auflage 1984.

Katschnig, H. and Konieczna T.: Angehörigenprobleme im Spiegel von Selbsterfahrungsgruppen. In: Angermeyer, M.C. & A. Finzen (Hrsg.): Die Angehörigengruppe - Familien mit psychisch Kranken auf dem Weg zur Selbsthilfe. Enke, Stuttgart 1984.

Katschnig, H. and Sint P.: Zwischen Selbsthilfe und Expertenhilfe: Die Angehörigenvereinigung "Hilfe für psychisch Erkrankte (HPE)" in Wien. In: Angermeyer, M.C. & A. Finzen (Hrsg.): Die Angehörigengruppe - Familien mit psychisch Kranken auf dem Weg zur Selbsthilfe. Enke, Stuttgart 1984.

SOCIAL AND EMOTIONAL ADAPTATION OF THE FAMILIES OF SCHIZOPHRENIC PATIENTS

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Our investigation has aimed at the assessment of the course of the social and emotional adaptation of the families in which one of the spouses had been diagnosed schizophrenic.

Material and methodology: 152 families have been investigated. All the patients, whose families were subject to investigation had been recruited from the hospital and the outpatient. The WHO criteria of schizophrenia had been adopted for the research purpose. The patient mental status was assesed by the standard mental status form similar to that used by WHO research on schizophrenia. Additional form was deviced to provide us with standardized data about the course of the illness. Family social structure and functional characteristics were assessed by the questionnaire called "Everyday life of the Polish family", which is the standard tool in research on family carried out by Polish Academy of Science. The spouse of the schizophrenic patient answered the questionnaire "Degree and direction of changes in the family". All the data were transferred onto perforated cards and statistically processed by means of a computer. Pearsons's, Kendall's coefficients were used to establish the correlations.

Results and conclusions: "Everyday life of the family"

Everyday life of 152 families with schizophrenic spouses has been compared with life in a group of 1832 Polish urban families. Both groups were assessed by the same questionnaire. Most fundamental indices in both groups such as age of both spouses, the length of marriage, the family's social status, their housing conditions and their standard of living proved very much alike, allowing us the further comparisons. The generation structure of

the family in both groups was largely similar. Small, nuclear families constituted 82% of the control group and 73% of families under investigation. This is clearly indicative of somewhat less marked, albeit equally high, tendency towards autonomy. Only in 10% of schizophrenic families a person from outside the family was employed to help the family. Also all contacts with relatives and social institutions were greatly similar in both groups, thus confirming the thesis about the vialability of the family ties within Polish families, contrary to Parson's conception of the isolation of a nuclear family.

The further findings point out the fact that the families with schizophrenic spouses are still capable of performing family functions in a manner hardly different from that customary in all Polish urban families. It was only in the recreational function that certain differences could be perceived, in form of the less active manner of taking advantage of leisure time, which was put down to the spouse illness. Moreover, the families under investigation did not show any differences from any average Polish family in the division of the routine household chores. Some 45% families of both groups displayed the egalitarian model, where household duties were fairly divided between two partners. In 7% of families the schizophrenic husband was totally exempt from discharging the household chores, but the ill wife was hardly ever free from doing at least some of the jobs.

The living conditions of children in the families under investigation, that is, their schooling, fun, as well as their leisure time was barely different from average Polish family. All Polish families, including those under investigation show very high aspirations in regard to the education of the children, while passing onto them fairly coherent value system with family life and vocational satisfaction in the foreground and other values treated as comparatively nonessential.

While analyzing all the findings of that part of our research one is tempted to conclude that in families with schizophrenic spouses, the illness is usually subordinated to all the functional requirements of the family. This means that many complex and integrated household activities must continue in order for the family to go on functioning adequately. The illness being a great threat to it calls for special adaptive mechanisms such as for example the emotional pressure upon the sick person to continue

his family role as long as possible, as well as the tendency to maintain the autonomy. The family seems to be by far more "important" than the illness, which may have a salutary effect upon the abnormal behaviour of the patient as he must subordinate to the requirements of the family. At the same time all the correct functioning of the family goes on at the expense of the ill person as well as his spouse as we shall see later. Otherwise the illness would slowly disorganize the family as it had been witnessed in a certain number of instances.

"Life with the illness"

This part of our research has aimed at assessing the relationship between the extent and the nature of changes in the family, being indicative of its adaptation to the illness and of some selected variables such as: sex of the ill person, his mental state, the course of the illness, the characteristic of the marriage and the personal qualities of the healthy spouse.

The group of 152 families has been divided into two subgroups: Group I - where the wife was the patient/88 families and Group II - where the husband was ill/64 families. Both groups of schizophrenic patients turned to be very much alike in what regard all the aspect of their illness. The dominating diagnosis was that of paranois schizoprenia, the average length of the illness came to 6.5 years. On the average the patients had been hospitalized three times, while the total length of their hospitalization time was coming up to 7 months.

The factor analysis of the mental stage pointed to the depressive factor being dominant in the entire population, closely followed by the schizophrenic factor which included Bleuler primary symptoms, manic factor and only on the fourth position the psychotic factor/delusions and hallucinations/.

Now, some 64% of the total number of the healthy spouses believed that the illness had markedly changed the life in the family, while 28% of them thought that the illness had barely influenced the actual family life.

The table below presents all the changes brought about by the illness into the particular function of the family.

Table 1

Family functions	Subgroups	No changes + positive changes	Negative changes	Chi^2 p
Economical	I N = 88	65 - 74%	23 - 26%	4.33
	II N = 64	37 - 58%	27 - 42%	0.96
Recreational	I N = 88	38 - 43%	50 - 57%	0.6
	II N = 64	24 - 38%	40 - 62%	0.52
Educational	I N = 82	59 - 72%	23 - 28%	11.01
	II N = 53	23 - 44%	30 - 56%	0.99
Sexual	I N = 88	38 - 43%	50 - 57%	1.2
	II N = 64	22 - 34%	42 - 66%	0.72
Emotional	I N = 88	55 - 62%	33 - 38%	0.94
	II N = 64	35 - 55%	29 - 45%	0.66
Security feeling	I N = 88	45 - 51%	43 - 49%	11.9
	II N = 64	15 - 23%	49 - 77%	0.99

The examination of the Table 1 shows that all the functions of the family have been subject to some measure of change, though to varied degrees. The least frequent changes are visible in the economical and educational functions of the family, as well as in emotional function. The recreational, sexual functions and the feeling of security have been changed more frequently and to a similar degree. The changes in all the family functions were significantly correlated, that means a change in one function of the family indicated high probability of the change in the next function.

All the changes in the economical, educational function and feeling of security depend significantly on the sex of the ill spouse, that is to say were more frequent in the Group II, in which the husband was ill. The changes in the recreational function remains the same regardless of the sex of the schizophrenic spouse.

In the healthy partner's opinion symptoms of the spouse which were most difficult to tolerate were: apathy, lack of initiative, difficulties in relating with other nervousness, suspisiousness, forming a so called "List of Deviant Family Behaviour". On that list the psychotic symptoms were rarely mentioned by the family. At the same time, all the family functions significantly correlated with the above mentioned symptoms as they also did with the schizophrenic factor from the factor analysis, while showing no correlation with the depressive factor for instance.

It seems therefore correct to draw conclusion that schizophrenia exerts some specific influence on family life, though there seems to exist a need for comparative investigation /affective disorders, alcoholism/.

Findings of our research also point towards significant relation between the number of hospitalizations and the total time spent in mental institutions and the frequency of changes in the functions of the family except the recreational one.

The other interesting finding was, that the husband of the schizophrenic woman had significantly less informations about the illness, than the wives of the ill husbands, while at the same time most family functions displayed strong negative correlation with the amount of the information. That means that the families who are better informed about the illness are usually not so well adapted to the existing situation. The protracted nature of the stresses and the minimal chance of seeing any happy outcome makes the family tend to cope with the illness successfully rather through some defensive mechanisms, particularly denial.

Amongst all the factors helping the family to cope with the illness, the first place was given to factors of the emotional nature, /love, attachment/, followed by some moral factors such as sense of duty, moral principles. The rational factors /common property, housing/ do not seem to be relevant in the process of coping with illness.

Finally, due to discriminating analysis method a special group of "high risk" families was isolated, that is families prone to disorganization by the illness. These are as a rule families where the husband is ill and shows symptoms as apathy, communication problems, poor sexual performance, and who was hospitalized more than three times. His wife knows a good deal about the illness, feeling at the same time deprived of her sense of security. Such families should primarily be accorded some psycho and sociotherapeutic care.

We hope that by virtue of our research the general knowledge about the families, where one of the spouses is schizophrenic will

increase. It may be better understood how hard the struggle is against the illness in order to carry on and cope with everyday life, the very fact of this struggle is well deserving our highest respect quite irrespectively of the ultimate outcome.

THE CONCEPT OF EXPRESSED EMOTION :

NEW EMPIRICAL EVIDENCE

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THE CONCEPT OF EXPRESSED EMOTION : NEW EMPIRICAL EVIDENCE

Expressed emotion (EE) was the term coined by Brown and Rutter (1966) for an index composed of several elements; critical comments, hostility, warmth and overinvolvement. Each element is a category of emotional response, which is rated from the audiotape of an interview with the relative of a patient. The interview is semi-structured and comprises questions about the patient's symptoms and behaviour during the past three months. The interview is usually held shortly after the patient's admission to hospital but can be given at any time. Ratings of the relative's EE depend not only on what is said, but also on the way in which it is expressed. Thus considerable attention is paid to vocal aspects of speech including rate, volume, and pitch. After a training programme of about three weeks, most candidates achieve an inter-rater reliability of over 0.8 on all elements of EE.

A number of studies have now been completed which reveal a highly significant association between relapse of schizophrenia and the expression of excessive criticism, hostility and overinvolvement by a relative (Brown et al., 1972; Vaughn and Leff, 1976; Vaughn et al., in press). The direction of cause and effect remained contentious until the publication of two recent studies, Leff et al. (1982) and Falloon et al. (1982), which showed that intervention with high EE families

could change the attitudes of relatives and thus improve the outlook for schizophrenic patients.

The link between high EE relatives and relapse of schizophrenia in the patients remains obscure, but can be broken down into a number of intermediate processes as shown in Figure 1. The relationship between adjacent processes has begun to be explored in some instances, while in others it is entirely speculative. Each relationship will be considered in sequence.

As explained above, the assessment of EE is made from an interview with the relative. It is assumed that the relative's emotional responses to questions about the patient closely reflect actual behaviour of the relative towards the patient. It is, of course, possible to observe family interactions in an experimental setting and work of this kind that is of relevance to EE has been done by Angermeyer and by Goldstein's group in Los Angeles.

Both studies employed Strodtbeck's (1951) Revealed Differences Technique to stimulate discussion between family members in families of schizophrenic patients, but their methods of analysing the interactions were different. Angermeyer (1982) used Content Analysis Scales developed by Gottschalk and Gleser (1969) and found that mothers of patients who were subsequently rehospitalised showed significantly more guilt anxiety and inwardly directed hostility than mothers of patients who were not re-admitted. On the other hand, the fathers of readmitted patients showed more outwardly directed hostility and

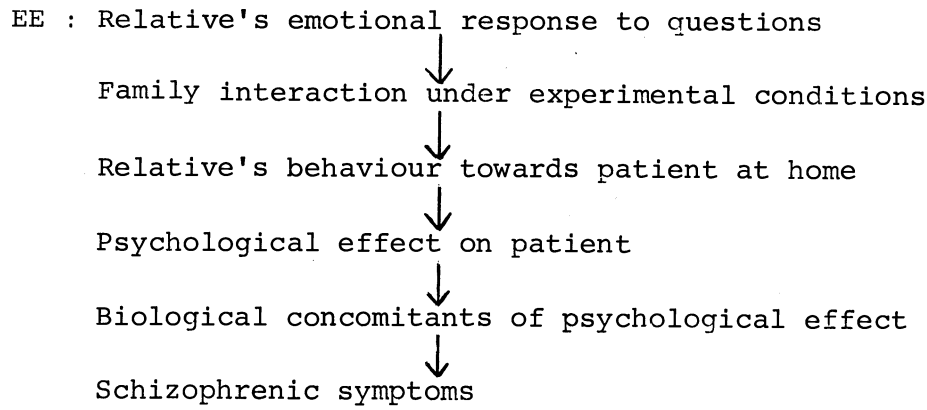

Fig. 1. The association between relative's EE and schizophrenic relapse : intermediate processes.

ambivalent hostility than fathers of the non-admitted group. There is an obvious equivalence between these emotional attitudes of the German fathers and the EE elements of criticism and hostility. In the case of the German mothers, Angermeyer speculates that their guilt and anxiety would lead them to become overinvolved with and overprotective of their sons. This is a weaker link with EE elements, but the data for the fathers confirm that the indirect measures of criticism and hostility have their counterparts in direct observations of family interaction in an experimental setting.

Even stronger evidence is provided by the study of Valone et al (in press) who measured EE in parents of schizophrenics and analysed direct interactions between these parents and their offspring. For the analysis they used the technique of Doane et al (1981) which categorises comments in terms of Affective Style. They found that high EE parents expressed significantly more benign criticisms and harsh criticisms towards their offspring than low EE parents. All but two of the 42 high EE parents concerned scored high on critical comments, hostility or both. Hence we can conclude that the differences found between high EE and low EE parents in their expression of benign and harsh criticisms are directly related to their EE ratings of criticism and hostility.

Together these two studies confirm that the indirect EE measures of relatives' criticism and hostility closely reflect the expression of these emotional attitudes towards patients in experimentally observed family interactions. Comparable work needs to be done on overinvolvement.

The next link in the chain is between family interactions in laboratory situations and the behaviour of relatives towards the patient in the home. It is impossible to observe human behaviour without potentially altering it, since people have to be informed they are being studies, for ethical reasons, and the self-consciousness this induces may well lead to less natural reactions. However, observations in the home are obviously less contrived than in the laboratory and can be made without the presence of an intrusive experimenter. It is theoretically possible to use bugging devices with the family's permission and this would be most likely to provide a record of natural interactions. To date, however, no such techniques have been employed, and we remain ignorant of the degree to which laboratory

observations of family discussions give a distorted view of interactions.

If we can make a speculative leap in the absence of data, and assume that high EE relatives actually make critical and hostile remarks to patients in the home or behave in an overinvolved fashion, the next question concerns the psychological effect this has on the patient. Here again we are faced with a total absence of information. However, we are about to embark on a study which should supply some of the answers. The aim is to elicit the emotional reactions of schizophrenic patients to viewing relatives expressing criticism, hostility and overinvolvement. For ethical reasons, we cannot show patients records of actual interactions. Instead we have used actors to reconstruct characteristic encounters between high EE relatives and schizophrenic patients. These have been videotaped and will be shown to a sample of schizophrenic patients in remission. The patients will be asked to identify the emotions expressed by the relatives they are shown, and the way viewing the tape makes them feel. At the same time, their skin conductance will be monitored in order to obtain an index of autonomic arousal.

This brings us to the next link; that between the psychological effects of high EE interactions on patients and the resultant biological disturbance. This may be conceptualised in biochemical or physiological terms, but for some time we have been using the psychophysiological concept of arousal to make sense of these effects. We have been relying on the rate of spontaneous fluctuations (SFs) of skin conductance to give an indication of the patient's level of arousal, and have found this pays off in terms of yielding interesting results.

In the first study of this kind skin conductance recordings were made in the patient's homes, initially in the absence of the relative, who was then brought in half-way through the session (Tarrier et al, 1979). The patients and relatives were part of the sample studied by Vaughn and Leff (1976) and were tested on average two years later. The initial EE ratings were used to divide the sample into high EE and low EE homes. At the beginning of the recording session both groups of patients had high SF rates of over 6 per minute. The patients in high EE homes remained at this level throughout the 30 minutes of recording and showed no sign of habituation. The entry of the high EE relative

produced a transient rise in the SF rate but had no enduring effect. The patients in low EE homes also remained at a high level for the first 15 minutes of recording, but as soon as their relative entered the room, their SF rate rapidly fell to normal levels, producing a highly significant difference from the level of high EE patients during the same period. We interpret this as indicating that the low EE relatives exerted a calming and reassuring effect on the patients, enabling them to habituate to the arousing experimental procedure.

This intriguing finding led us to extend the work to acutely ill schizophrenic patients. In a recent study the same experimental paradigm was used for patients who had been in hospital for an average of six weeks (Sturgeon et al, in press), except that the recording took place in the hospital instead of at home. The striking finding from this study was that high EE and low EE patients differed significantly in SF rates from the beginning of the recording, before the entry of the relative. In fact the high EE patients had a mean SF rate of 11.1 per minute, almost double the rate of 5.8 for the low EE patients. Our interpretation of this is that schizophrenic patients living with high EE relatives develop high levels of arousal when they relapse, and that these persist for some weeks after admission despite treatment. By the time we recorded the SF rates of acutely ill low EE patients they were no different from the rates Tarrier et al found in a state of remission. We assume that there had been a transient rise in arousal paralleling the appearance of schizophrenic symptoms, but that we missed this by recording six weeks after admission. This assumption evidently needs to be tested by carrying out such recordings within a few days of admission.

In discussing these findings we have made the tacit assumption that the patient's level of arousal is directly related to the appearance of schizophrenic symptoms. However this is actually the last link in the chain, for which evidence is required. Of course this applies not only to psychophysiological indices of arousal, but to any biological variable that is proposed as important in the pathogenesis of schizophrenia. We do have some evidence linking SF rates to schizophrenic symptoms. In a recent study, Cooklin et al (1983) selected schizophrenic patients who gave non-verbal evidence of intermittent auditory hallucinations, usually eye movements of a particular kind. This was chosen in preference to self-report, which we consider

to be unreliable. Skin conductance was recorded for 30 minutes while the patient was videotaped. The skin conductance record was scored for SFs and the video recording was rated independently for periods of auditory hallucinations. When the two sets of ratings were synchronised it was found, as predicted, that the onset of hallucinatory periods was significantly ($p < 0.01$) associated with a rise in the SF rate. This finding does not indicate the direction of cause and effect, but it represents the first step towards establishing a relationship between biological variables and schizophrenic symptoms.

It might be argued that a detailed consideration of the processes mediating the effect of relatives' EE on schizophrenic relapse is unnecessary for the practical management of patients and their families. However it is essential for an understanding of the way in which social stress interacts with an inherited biological vulnerability. If we can devise studies that enable us to forge the links in this chain, there is the hope of uncovering the pathogenesis of schizophrenia and of eventually finding a cure.

References

Angermeyer, M.C., 1982, The association between family atmosphere and hospital career of schizophrenic patients, Brit. J. Psychiat., 141:1.

Brown, G.W., Birley, J.L.T., and Wing, J.K., 1972, Influence of family life on the course of schizophrenic disorders : a replication, Brit. J. Psychiat., 121:241.

Brown, G.W., and Rutter M., 1966, The measurement of family activities and relationships : a methodological study, Human Relations, 19:241.

Cooklin, R., Sturgeon, D., and Leff, J., 1983, The relationship between auditory hallucinations and spontaneous fluctuations of skin conductance in schizophrenia, Brit. J. Psychiat., 142:47.

Doane, J.A., West, K.L., Goldstein, M.J., Rodnick, E.H., and Jones, J.E., 1981, Parental communication deviance and affective style, Arch. Gen. Psychiat., 38:679.

Falloon, I.R.H., Boyd., J.L., McGill, C.W., Razani, J., Moss, H.B., and Gilderman, A.M., 1982, Family management in the prevention of exacerbations of schizophrenia : a controlled study, New Eng. J. Med., 306:1437.

Gottschalk, L.A., and Gleser, G.C., 1969, "The Measurement of Psychological States Through the Content Analysis of Verbal Behavior", California Press, Berkeley.

Leff, J., Kuipers, L., Berkowitz, R., Eberlein-Fries, R., and Sturgeon, D., 1982, A controlled trial of social intervention in the families of schizophrenic patients, Brit. J. Psychiat., 141:121.

Strodtbeck, F.L., 1951, Husband-wife interaction over revealed differences, Amer. Sociol. Rev., 16:468.

Sturgeon, D., Turpin, G., Berkowitz, R., Kuipers, L., and Leff, J., in press, Psychophysiological responses of schizophrenic patients to high and low expressed emotion relatives:a follow-up study, Brit. J. Psychiat.

Tarrier, N., Vaughn, C.E., Lader, M.H., and Leff, J.P., 1979, Bodily reactions to people and events in schizophrenia, Arch. Gen. Psychiat., 36:311.

Valone, K., Norton, J.P., Goldstein, M.J., and Doane, J.A., in press, Parental expressed emotion and affective style in an adolescent sample at risk for schizophrenia spectrum disorder, J. Abnorm. Psychol.

Vaughn, C.E., and Leff, J.P., 1976, The influence of family and social factors on the course of psychiatric illness. A comparison of schizophrenic and depressed neurotic patients, Brit. J. Psychiat., 129:125.

Vaughn, C.E., Snyder, K.S., Jones, S., Freeman, W.B., and Falloon, I.R.H., in press, Family factors in schizophrenic relapse : a replication of the British research on expressed emotion, Arch. Gen. Psychiat.

HELPING FAMILIES OF SCHIZOPHRENIC PATIENTS: AN ECLECTIC APPROACH

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By the end of 1977 the concept of Expressed Emotion (EE) had been well established in London as a reliable predictor of subsequent relapse when schizophrenic patients return home to live with their families (Brown, Birley and Wing, 1972; Vaughn and Leff, 1976a). It was clear at this stage that the next step was to mount an intervention study in order to find out if one could reduce schizophrenic relapse rates. Because we knew specifically that staying on medication was protective while high social contact was a risk factor, we concentrated on a small group of schizophrenic patients; those returning to high EE homes (high EE is now defined as a relative making more than six critical remarks or a rating of more than 3 on overinvolvement during the shortened Camberwell Family Interview (Vaughn and Leff, 1976b)), and also spending more than 35 hours per week with high EE relatives, who we knew were at high risk of subsequent relapse. Even on medication the relapse rate for this group of patients in the nine months after hospital discharge was 54% (Vaughn and Leff, 1976a).

At this time no other similar intervention study had been undertaken with this particular group of patients. Although they represented only about 1/6th of schizophrenic patient admissions, because they were a high risk group they were also the ones who were likely to be re-admitted to hospital in the future, and because their relatives were high EE were also likely to be the "difficult" families whom staff did not find easy to cope with. As such, intervention with these families seemed likely to provide useful pointers for future studies.

While the aims of an intervention project were clear; to reduce social contact and/or to reduce levels of EE, the optimum

methods to be employed were not. The EE results had been derived from the empirical research of the previous twenty years, but EE remained essentially an esoteric measurement (Kuipers, 1979). At this stage it was not clear whether EE levels in relatives could be altered at all. Neither was it clear in which ways this should be attempted. Thus we chose an eclectic approach. We decided to compile a 'package' of social interventions to be applied flexibly to individual families, and to compare it with 'standard hospital care' given to a control group. This approach obviously did not allow us to control for the effects of therapist attention alone, nor enable us to decide which elements of the 'package' had been most effective. The latter is currently being done by Dr Leff in a new study.

Our eclectic approach consisted of three main elements:

1) Education for the relatives at home which was assessed separately.
2) Relative group meetings held fortnightly.
3) Family sessions in the home.

This was accompanied by some patient counselling and by phone contact. The total amount of time spent on these interventions by the therapeutic team in the nine months after a patient's discharge from hospital was not excessive and averaged 22 hours per family.

The rationale for these elements was derived from all the information that we had available at the time. Firstly, it was known from a content analysis of the critical remarks made by relatives (Vaughn, 1977) that high EE relatives in particular tended not to recognise that there was an illness process, but to blame the patient for irrational or bizarre behaviour. This was in contrast to low EE relatives who tended to realise that there was something 'wrong' even if they could not identify it. This latter attitude seemed to be one of the reasons underlying low EE relatives' ability to understand and tolerate behaviour that high EE relatives found inexplicable and annoying.

It was thus felt that some education where simple information was conveyed to relatives at home about the diagnosis, aetiology, treatment and course of schizophrenia might be helpful. The impact of this education programme was assessed separately (Berkowitz et al, 1983). Not many specific effects were found in terms of the information retained, apart from relatives remembering the diagnosis of schizophrenia, but it seemed likely that the non specific effects of modelling a more open relationship between relatives and professionals, introducing ideas about unknown causes and suggesting that treatment was not confined to medication effects, might have begun the more general process of reducing levels of EE in the experimental group.

The relatives group was initially designed as a forum where both low and high EE relatives could meet and exchange ideas about

how to cope with problems. It was known, from a review of the literature before the study began, that these families were not a particularly co-operative group, were suspicious of professional help, (often with good reason from past experiences), and were likely to drop out of treatment (e.g. Hudson, 1975). It was felt that an open ended group, including some low EE relatives who were coping, as well as those who did not, and having a basically self help format might reduce this tendency. It was also a similar format to that being used by other workers at the time (Atwood and Williams, 1978; Priestly 1979). The group ran fortnightly for nearly five years with a mode of four relatives. Not only were problems and ways of coping discussed, but also issues about relatives' own feelings of guilt and blame, and continuing issues relating to the education programme: what was the cause of schizophrenia, what other treatment was there. The group also appeared to serve other functions. It helped to reduce relatives' isolation; they often had very small social networks. Finally, because the patient was not included, it provided somewhere 'safe' where problems could be discussed. High EE relatives, in particular, often felt very constrained and inhibited by the patient - they knew that open confrontation 'upset' the patient and so tried to hide their annoyance or upset, often at great cost to themselves; "I feel suffocated by him", as one wife put it. Having somewhere to off load these feelings without any comeback from the patient was often a great relief to relatives and appeared to be a necessary first step for some before actual changes in coping styles or attitude could be risked.

The family sessions were initially designed as additional meetings for the families where contact patterns could be discussed more individually and both relatives and patients could be encouraged to be more independent. However, it soon became apparent, perhaps because we had chosen this particular group of high EE and high social contact families, that the two facets interacted. Those whom one might want to separate most clearly were usually those with the highest EE attitudes and who thus did not allow it. As one mother put it, "I would worry <u>more</u> if I was out of the house".

It became clear that increasing patients' and relatives' independence was usually possible only after high EE attitudes had moderated. Earlier attempts to separate families physically, by going to hostels or day centres tended to be sabotaged by the family unless some prior attitude changes had been achieved. It was also not feasible or desirable to separate all families - one was unlikely to be able to reduce contact below 35 hours a week for spouses for instance. Thus the family meetings over the five years of the study became more prominent and we tended to offer more of them to families as the study progressed. This enabled wider issues to be discussed and also meant that we included two influential but low contact fathers whom otherwise we might not have engaged in treatment.

Altogether 49 families were eligible for the study which is described in more detail elsewhere (Leff et al, 1982). All patients were diagnosed as schizophrenic using the PSE (Wing, Cooper and Sartorious, 1974) and CATEGO. Of these 9 refused (18% refusal rate) and 40 were included in the study and placed on long term medication. Of these 25 were high EE, and 12 were randomly allocated to an experimental group and given the above social intervention. The other 12 were placed in the control group and received standard hospital care from their clinical teams. (One control patient received our social interventions from the clinical team and was thus lost to the study). Patients were re-assessed on the PSE at nine months after discharge from hospital or earlier if they relapsed. A two year follow up has also just been completed.

What we found was firstly, that using this broad approach, we were able to reduce EE levels in the experimental relatives, particularly the number of critical remarks, as shown in Table I.

Table I

EE ratings of relatives: means and standard deviation

Initial EE ratings		Follow up EE ratings		
Relatives who made more than 6 critical remarks.				
Exp. group (N=12)	16.75 ±10.91	(N=12)	6.67 ± 5.52	t=3.7 p<0.005
Control group (N=9)	12.0 ±10.16	(N=6)	10.83 ±11.53	n.s.
Initial EE ratings		Follow up EE ratings		
Relatives who initially had more than 3 on overinvolvement.				
Exp. group (N=5)	4.0 ± 0.7	2.4	± 1.3	0.1>p>0.5
Control Group (N=6)	4.0 ± 0.89	3.7	± 0.8	n.s.

Overinvolvement did not change significantly in either group probably because it is a more well established attitude often with roots in relatives' early parenting style with that particular child.

The relapse rate of the experimental group was also significantly reduced compared to the control group, over the nine months after patients' hospital discharge. This was re-assessed using the PSE and CATEGO and was independent of hospital re-admission policies. See Table II overleaf.

Table II

Nine Month relapse rates

Exp. group	8%	(1/12)	$p < 0.02$
Control group	50%	(6/12)	

Table III

EE and face to face contact at nine month follow up.

Relative	EE Level	Contact	Aims Achieved
Mother	Low	Low	✓
Father	Low	Low	✓
Husband	Low	High	✓
Wife	High	High	✗
Wife	Low	High	✓
Wife	High	Low	✓
Wife	Low	High	✓
Mother	Low	High	✓
Husband	High	Low	✓
Mother	High	Low	✓
Mother	High	High	✓
Mother	High	High	✗
Mother	Low	High	✓

Finally, it was of interest to note that in the 75 per cent of families where we achieved our experimental aims of either reducing social contact below 35 hours per week or of reducing EE levels to below six critical remarks or a rating of less than 3 on overinvolvement, no relapses occurred. See Table III.

We have also just completed a follow up of patients two years after their discharge from hospital. The results are slightly complicated by patients who did not remain on medication during the whole of this time, two in the experimental and two in the control group. If those who remained on medication are compared, the effects of the social interventions appear to be sustained in that there was an 80% (8/10) relapse rate in the control group and a 40% (4/10) relapse rate in the experimental group. In the experimental group where we achieved our intervention aims of low EE or low contact, there was only a 14% relapse rate (1/7). This was in marked contrast to the 3 families where we did not achieve our aims, where tragically there were two suicides and one relapse. In the total group, the number of months until relapse was also significantly different, being 12 months for the control group (N=12) and 20 months for the

experimental group (N=12)($p < 0.05$). In the experimental group the ones who remained well appeared concentrated in the group which had reduced EE levels, as if only social contact had been reduced, patients tended to relapse quickly if they came off their medication, as one would predict.

These results are confirmed by Falloon et al's study (1982) which used a slightly different group of families and compared two specific treatments. This seems to augur well for the effectiveness of social intervention strategies in general in improving the prognosis of schizophrenic patients still in contact with the resource of a family network. It also suggests that it is worthwhile to try and elucidate the precise mechanisms involved in the process, currently in progress, with the aim of enabling therapists to offer more specific help to families who are still involved in caring for and living with a schizophrenic patient.

I would like to end with a quote from a husband who, before our intervention, was talking of separating from his wife;

"I now do understand that she found things difficult, and they don't get on my nerves anymore".

References

ATWOOD, N, and WILLIAMS, M. Group support for families of the mentally ill. Schizophrenic Bulletin, 1978. 4, 415 - 425.

BERKOWITZ, R, EBERLEIN-FRIES, R, KUIPERS, L, and LEFF, J. Educating relatives about schizophrenia. Paper submitted to Schizophrenia Bulletin, 1983.

BROWN, G.W., BIRLEY, J.L.T. and WING, J.K. Influence of family life on the course of schizophrenic disorders: a replication. British Journal of Psychiatry, 1972. 121, 241 - 258.

FALLOON, I.R.H., BOYD, J.L., McGILL, C.W., RASINI, J., MOSS, H.B. and GILDERMAN, A.M. Family management in the prevention of exacerbations of schizophrenia: a controlled study. New England Journal of Medicine, 1982. 306, 1437 - 1440.

KUIPERS, L. Expressed Emotion: a review. British Journal of Social and Clinical Psychology, 1979. 18, 237 - 243.

LEFF, J., KUIPERS, L., BERKOWITZ, R., EBERLEIN-FRIES, R. and STURGEON, D. A controlled trial of social intervention in the families of schizophrenic patients. British Journal of Psychiatry, 1982. 141, 121 - 134.

PRIESTLY, D. Tied together with string. National Schizophrenia Fellowship, Surrey, England, 1979.

VAUGHN, C.E. Patterns of interactions in families of schizophrenia. In H. Katschnig (ed) Schizophrenia the other side, Vienna; Urban and Schwarzenberg, 1977.

VAUGHN, C.E. and LEFF, J.P. The influence of family and social factors on the course of psychiatric patients. British Journal

of Psychiatry, 1976a. 129, 125 - 137.
VAUGHN, C.E. and LEFF, J.P. The measurement of expressed emotion in the families of psychiatric patients. British Journal of Social and Clinical Psychology, 1976b. 15, 157 - 165.
WING, J.K., COOPER, J. and SARTORIOUS, N. The Description and Classification of Psychiatric Symptoms: An instructional manual for PSE and CATEGO System. London, Cambridge University Press, 1974.

THE CAMBERWELL-FAMILY-INTERVIEW AS DIAGNOSTIC AND THERAPEUTIC TOOL

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We are presenting preliminary results from a research project in Hamburg on diagnosis and therapy with young, relapse prone schizophrenic patients and their relatives.[+] Using the Camberwell-Family-Interview we made an attempt to identify patients who are in contact or are living with high-emotional-involved (high-EE) relatives. These patients are more than others expected to be relapse prone (BROWN, 1968, 1972; VAUGHN and LEFF, 1976; VAUGHN et al., 1982). During the last 30 months (1980-1983) we have interviewed with the Present-State-Examination (PSE) 120 patients who were clinically diagnosed as schizophrenics. 52 patients and their families were selected by the following criteria: Presence of nuclear symptoms during the last 4 weeks (PSE); age 18-30 years; maximum duration of illness 3 years; maximum duration of hospitalisation (total) 1 year; no more than 3 admissions before; key relatives available.
29 patients were from families with at least 1 high-EE relative (according to the CFI-rating). Half of them were included in therapy-groups (patients- and relative-groups). The other half and patients from low-EE families were observed as controls. CFI and PSE were repeated after 1/2, 11/2 and after 21/2 years. A special relapse rating interview is done 9 months and 2 years after discharge.

[+] Supported by Deutsche Forschungsmeinschaft, Sonderforschungsbereich 115, Universitätsklinik Hamburg-Eppendorf, Psychiatrische und Nervenklinik, ärztlicher Direktor Prof.Dr.Jan Gross.

The Hamburg CFI-study: Results in Comparison

Table 1 shows a comparison of the Hamburg, British and California CFI-studies. The Hamburg sample differs from the others in several aspects: Patients are younger, less chronically ill, and our diagnostic criteria do not include other symptoms than the Nuclear Symptoms of the PSE.[+] Therefore, the 3 samples of patients are not directly comparable.

The 3 studies differ also in regard to the relatives interviewed. In the British sample the percentage of parents is only half of the percentage of the California study, whereas the percentage of spouses is much higher (38% vs 6%). The Hamburg sample lies in between these two, but resembles more the California study. The number of patients of whom both parents were interviewed, is in the California and Hamburg sample higher than in the British one. These differences regarding patients and interviewed relatives are important if we look at the results of the CFI. Thus, table 1 shows that the percentage of high-EE-families is highest in the California study (75%), second in the Hamburg study (56%) and lowest in the British study (45%). What are the reasons for these differences?

We can assume that the CFI was used in the same way in all studies, because we were trained by Christine VAUGHN and Karen SNYDER. Therefore, 3 sources of differences remain.

First: Cultural differences in the attitude of the families to schizophrenic patients as VAUGHN et al.(1982) assumes. Ongoing international comparative studies may clarify this question; however, we do not think this is the main point.

Second: Differences in the selection of patients. It is possible that age, diagnosis or duration of illness correlates with the attitude of relatives. In the California study for example, many of the patients (55%) had been ill for more than 5 years. They may represent a special selection of patients with a bad prognosis and thus, the majority may come from high-EE-families. On the other hand, the duration of the illness may provoke a high-EE reaction of the relatives.

The third possibility seems to us most worthwhile to consider: Differences in the relatives interviewed. Indeed, further analysis of our own data (tab.2) shows that the probability of identifying patients from high-EE-families depends on the number and type of relatives tested. If both parents are available, the percentage of

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[+] The British study used PSE and Catego-programme as diagnostic tools, the California study Nuclear Symptoms (PSE) and incoherence of speech (PAS).

Table 1. AN OVERVIEW ABOUT 3 CFI-STUDIES

	British study 1)	California study 2)	Hamburg study
Number of patients	37	69	52
Age of patients in years	17 - 64	17 - 50	18 - 30
Diagnosis	Schizophrenia Catego-progr.	Schizophrenia (PSE) incoherence of speech (PAS)	Nuclear Symptoms (PSE)
Number of first /second admission	20 (54%) ?	12 (17%) ?	36 (69%) 48 (92%)
Duration of illness more than 5 years	10 (28%)	29 (42%)	4 (8%)
Type of families			
Parent-households	17 (46%)	63 (91%)	47 (90%)
Spouse-households	14 (38%)	4 (6%)	5 (10%)
Others (sibs)	6 (16%)	2 (3%)	0 (0%)
Number of relatives interviewed	46	105	79
Types of relatives interviewed			
Parents	?	99 (94%)	67 (85%)
Spouses	14 (30%)	4 (4%)	8 (10%)
Others	?	2 (2%)	4 (5%)
Both parents interviewed	?	36 (52%)	20 (38%)
Number of high-EE families			
Total	17 (46%)	52 (75%)	29 (56%)
If one parent is interviewed	no informat.	no inform.	12/27 (44%)
If both parents are interviewed	no informat.	no inform.	16/20 (80%)

1) VAUGHN and LEFF (1976) 2) VAUGHN et al. (1982)

high-EE-families is much higher than in patient families where we were able to interview only one parent (80% vs 44%). This result seems almost trivial because the probability to find a specific observation increases the more observations are made. However, as far as we know, this observation has not been reported as of yet. On the other hand, we found less high emotional reactions in spouses compared to the one parent situation (12% vs 44%). This observation is in line with descriptions by VAUGHN (1976). The low number of high-EE-families in the British sample may partially be explained by the fact that a high percentage of spouses was interviewed. Our findings permit the assumption that high-EE-family is an almost ubiquiterian characteristic for at least acute schizophrenics, especially if it is possible to interview enough and the key members of a patient's social network. Repeated assessments in our study further show that almost all schizophrenics have at least once over a short time course (18 months) a high-EE-family member: Of 23 families, interviewed 3 times within 18 months, 19 (83%) had at least once a high-EE reaction.

These findings are backed up by an analysis of low-EE-families. We have already mentioned the fact that we found especially few low-EE-families if we interviewed the spouses and especially many if we interviewed both parents.

In table 3 we have analysed the 15 low-EE-families with only one parent interviewed. Only 4 of these patients came from households with both parents. 11 were living in a kind of broken home situation (parents divorced; one parent died; illegitimate birth, no stepfather). The interviewed parent was asked about the attitude of the non available parent towards the patient. 6-7 of them were discribed as critical, hostile or emotionally overinvolved. This, surely is a crude estimate. However, it clearly suggests that we would have found more high-EE-families if we had been able to interview both parents and/or another key-relative (e.g. grandparents).

Provided, further studies confirm our results that high-EE-families, especially in parents families, are much more common among schizophrenics than assumed up to now, the question of the specifity of high-EE-families for schizophrenic diseases, compared to other psychiatric and psychosomatic illnesses has to be discussed (VAUGHN and LEFF, 1976). This includes the question, whether high-expressed-emotions are only determining the course of schizophrenia and the probability of short time relapse or whether high-expressed-emotion is an etiological factor in schizophrenia. This seems plausible because the CFI is not a measure of reaction to symptoms but a measure of the attitude toward the patient, independent of the acute illness. We are going to investigate part of this problem in a study of expressed-emotions in other diseases.

Table 2. LOW AND HIGH-EE-FAMILIES; BY NUMBER AND TYPES OF RELATIVES INTERVIEWED

	High-EE	Low-EE
Both parents N = 20	16 (80%)	4 (20%)
One parent N = 27	12 (44%)	15 (55%)
Spouses N = 5	1 (20%)	4 (80%)
Total N = 52	29 (56%)	23 (45%)

Table 3. ANALYSES OF THE LOW-EE-FAMILIES, in which only one parent was interviewed (N = 15)

Reasons of inavail-ability of parent	Number of cases	Interviewer describes non interviewed spouse as critical,hostile and/or EOI
Both parents living together, one re-jected interview	4 (27%)	3 - 4
Parents divorced	5 (34%)	2
One parent died	3 (20%)	1
Illegitimate birth of patient	3 (20%)	inapplicable
Total	15 (100%)	6 - 7 (40-46%)

Table 4. CFI FOLLOW UP RESULTS+

	Number of relatives	High-EE	Low-EE	Percentage high - EE
1. CFI	79	35	44	44%
2. CFI 6 months later	60	20	40	33%
3. CFI 18 months later	32	9	23	28%

+ Data for relatives (not families)

Table 5. STABILITY OF CFI RESULTS[+]

2.Interview (6 months follow up)

1. Interview	high EE	low EE
high EE	15	(15)
low EE	(5)	25

N = 60; $p \leq .05^{++}$ +

3.Interview (18 months follow up)

1. Interview	high EE	low EE
high EE	7	(12)
low EE	(2)	11

N = 32; $p \leq .01^{++}$ +

3.Interview (18 months follow up)

2.Interview 6 months follow up	high EE	low EE
high EE	8	(6)
low EE	(0)	17

N = 31; $p \leq .05^{++}$ +

[+] Data for relatives (not families)

[++] Statistical significance for frequency of changes from high to low EE vs from low to high EE (circled figures); according to sign-test.

We expect, in accordance with the high-risk-prospective studies by M. GOLDSTEIN (1978), that high-expressed-emotions might be specific for families of schizophrenics.

Changes in CFI - scores in the Follow up Period

Because the therapy study is not yet finished, we only present some preliminary results about changes in CFI-scores for the total sample (treated and untreated groups). Up to now, we have started with 4 therapy groups for relatives: 2 weekly, 2 monthly. Only one monthly group is finished after 2 years as a self-help-group. A second group is ongoing till this autumn (KÖTTGEN et al., a und b, 1983).

Table 4 shows that the percentage of high-EE-relatives becomes successively lower the more time has passed since admission.

Table 5 shows this in more detail. There are significant decreases in high-EE reaction between interview 1 and 2 (first follow up), interview 1 and 3 (second follow up) and interview 2 und 3.

2 questions result from these data:
1. Are high-EE reactions a kind of crisis-fever toward acute illness of a patient and may as well occur in other families, dependent on acute and serious crisis situations? (We will examine this possibility in our aboved mentioned planned research project).
2. Are those relatives,who remain high-EE,the most risky members for patients? Is their high-EE reaction a response to the disturbance of patient or is this reaction independent of the illness of the patient?

REFERENCES

BROWN, G.W.; MONK, E.M.; CASTAIRS, G.M.; WING, J.K.: Influence of family life on the course of schizophrenic illness. Brit.J. Prevent.Soc.Med.16, 55-68, 1968.

BROWN, G.W.; BIRLEY, J.L.T.; WING, J.K.: The influence of family life of schizophrenic disorders. Brit.J.Psychiat. 121, 241-258, 1972.

CIOMPI, L.; MÜLLER, C.: Lebensweg und Alter der Schizophrenen. Eine katamnestische Langzeitstudie bis ins Senium. Berlin, Heidelberg, New York; Springer, 1976.

GOLDSTEIN, M.; RODNICK, E.K.; JONES, J.E.; McPERSON, S.; WEST, K.: Familial precusors of schizophrenia spectrum disorders. In L.Wynne; R.Cromwell; S.Matthysse (ed.): The nature of schizophrenia: New approaches to research and treatment. New York, (John Wiley) p.487-498, 1978.

HUBER, G.; GROSS, G.; SCHÜTTLER, R.: Schizophrenie. Eine Verlaufs- und sozialpsychiatrische Langzeitstudie. Berlin, Heidelberg, New York, Springer, 1979.

KÖTTGEN, C.; MOLLENHAUER, K.; SÖNNICHSEN, I.; JURTH, R.; HAND, I.: Therapie mit Angehörigen von jungen rückfallgefährdeten schizophrenen Kranken. In M.C.Angermeyer (ed.): Angehörigengruppen. Familien mit psychisch Kranken auf dem Wege zur Selbsthilfe. Enke-Verlag, 1983.

KÖTTGEN, C.; HAND, I.; MOLLENHAUER, K.; SÖNNICHSEN, I.: Relatives' groups and patients' groups for prevention of relapse in young schizophrenics: An evaluation of risk factors from the Camberwell-Family-Interview and of interventions for their modification. Mimeographed, 1982.

VAUGHN, C.; LEFF, J.: The influence of family and social factors on the course of psychiatric illness: A comparison of schizophrenia and depressed neurotic patients. Br.J.Psychiat. 129, 125-137, 1976.

VAUGHN, C.; LEFF, J.: The measurement of the expressed emotions in the families of psychiatric patients. Br.J.Soc.Clin. Psychol. 15, 157-165, 1976.

VAUGHN, C.; SNYDER, K.S.; SIMON, J.; FREEMAN, W.; FALLOON, I.R.H.: Family factors in schizophrenic relapse. A california replication of the british research on expressed emotion. Mimeographed, 1982.

HELPING THE FAMILY TO COPE WITH SCHIZOPHRENIA:

STUDENTS AS GROUP THERAPISTS

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INTRODUCTION

Psychotherapeutic treatment concepts in which the schizophrenic patient's relatives take part are presently gaining importance. The reasons for this are evident. Specially since the findings of Brown et al. (1972) and Vaughn and Leff (1976) concerning 'Expressed Emotion', it can be assumed that the prevention of relapse can be increased by involving the patient's relatives.

With the development of these treatment concepts, the question arises as to how therapists should be trained for such an intervention and (taking into account the limitations of clinical practice) as to how it is possible to implement these therapy programs. One way to solve this last problem is to engage psychology students as therapists.

The hypothesis was that psychology students in their last year of clinical psychological education are able to conduct a therapeutic program involving families of schizophrenic patients effectively if they are intensively trained and supervised. The treatment model which was developed contains elements of psychotherapy, psychoeducation and self-help. Corresponding to this program, a strategy for the instruction of therapists was developed. In a study with psychology students as therapists, the effects on relatives, therapists and patients were evaluated.

THERAPY CONCEPT

The treatment model is that of separate group therapies for patients and relatives (Buchkremer and Fiedler, 1982). Goals for

the relatives are mainly:
- th decrease feelings of guilt and helplessness,
- to increase understanding of the patient and his illness-related deficits,
- to reduce emotionally intensive family interactions and
- to improve family coping styles by increasing the family's self-help potential.

Goals for the patients are mainly:
- an improved way to deal with the illness,
- a better way to solve everyday difficulties and
- to recognize relapse symptoms at an early stage and react adequately to them.

The components of both interventions are as follows:

Table 1. Components of the Group-Therapy Concept for Relatives of Schizophrenic Patients

1. Home Visit	
2. Information about Schizophrenia	- theories of etiology - symptoms - course of illness - prognosis - medication
3. Focussing on Individual and Family Problems	- current problems - communication and problem-solving strategies - long-term strategy - re-establishing social network
4. Preparation for Eventual Relapse	- recognizing early relapse symptoms - adequate crisis intervention
5. Transition to Self-Help-Groups	

Before the actual beginning ro the therapy, the therapists meet the relatives and the patient in the family's home to explain the project and get acquainted with the familiy.

The first group sessions in patient's and relatives' groups then are educational sessions about issues concerning schizophrenia. The relatives are informed about relevant facts concerning etiology, symptoms, course of illness, prognosis, treatment models and prevention. They obtain detailed information about neuroleptic medication and its effects and side effects.

A considerable part of the therapy is reserved for focussing on individual and family problems and their solution. The relatives have the opportunity to describe their difficulties. With the help

of the therapists and the other group members, ideas are developed for new communication, interaction and problem-solving strategies.

Another component is the early recognition of relapse symptoms and adequate ways to deal with the re-occurrence of a psychotic exacerbation. Early crisis intervention enables rehospitalization to be avoided.

Towards the end of the therapy, the therapists prepare the actual transistion of the group to a self-help group.

The group sessions are conducted by two therapists, have 4 - 6 participants and meet weekly for about three months.

TRAINING CONCEPT

According to the requirements of the therapeutic interventions described above, a training concept was developed to enable students to conduct such a therapy effectively.

Students that seem qualified for this kind of project are those in the 7th semester, i.e. in their last year of clinical psychological education. At this time, they have a relatively broad theoretical background. Basic clinical psychological competence can therefore be expected.

Main objectives of the training are:
- a detailed knowledge about psychiatry and specifically schizophrenia,
- a problem and client-oriented therapeutic behaviour as well as competence to deal with difficult therapy situations such as resistance, aggression etc.,
- to get to know the specific problems families of schizophrenic patients have.

Besides this, goals of the training were:
- getting to know the psychiatric care system,
- competence to cooperate in a multidisciplinary team and
- competence to evaluate critically the effects of therapeutic work.

These goals are to be realized in an intensive theoretical and practical training consisting of four phases:

Phase I: Self-instruction about general issues of psychiatry and schizophrenia

Phase II: Seminars about specific issues of schizophrenia, training sessions of basic therapeutic skills, internship in psychiatric inpatient department

Phase III: Seminary about research methodology and treatment concepts, training sessions of complex therapeutic skills, intern-

ship in psychiatric outpatient department
Phase IV: Supervised implementation of therapeutic intervention, data collection and evaluation.

Each phase last for about three months; the entire training amounts to about 4oo hours.

EVALUATION

When the project was concluded, it had 15 participating students. They were accepted after an interview and a written test. 47 patients participated at the project, 24 relatives of 14 patients took part in the therapy program for relatives.

Students

Weekly the students filled out questionnaires about critical events associated with the project and the estimated effect these events had on their therapeutic competence.

The results show that the students all experienced an enormous increase of competence by the training. This increase is mainly attributed to the practical work (Fiedler et al., 1982). Almost every student experienced one or more events of what one might call practice shock. In fact those events were considered as producing the highest increase of competence if supervision and advice by the other students were available at that time.

Difficult situations which caused those feelings of inadequacy and helplessness associated with practice shock were e.g.:
- Too high expectations concerning an abvious change in the families by the therapy. If this change did not occur, the students tended to be more directive in the sessions. This of course was answered by the relatives with resistance and missing sessions. In situations like these it was helpful that two therapists conducted the groups.
- The fact that the therapists were still in the role of learning students instead of experts and the groups knew about this fact made it easier for the students to admit insufficiencies and give the responsibility back to the family.

They reported an extraordinary amount of positive feedback especially from the group of relatives, a reinforcer that encouraged and motivated them.

Relatives

At the end of the treatment, relatives filled out a question-

naire about changes concerning attitudes and behaviour towards the patient and his illness. They reported that the therapy helped them a lot that they felt supported and understood and experienced a distinct decrease of negative attitudes towards the patients. The data show that the participating relatives felt more competent to deal with their situation significantly more often after the therapy than non-participating relatives. They reported that they appreciated the therapists and found them competent. After the project, they continued to keep in contact with the other group members.

Patients

In the group of patients without participating relatives at the time of the two-year followup, severe psychotic symptoms have been observed twice as frequently as in the group with participating relatives. Re-occurrences were significantly more often in this group and each re-hospitalization was longer than in the other group. The participation of relatives in the therapy process seems to have a stabilizing effect on the course of illness and to improve the patients ability to cope with a relapse without further therapeutic help. Patients with relatives who participated in the program reported that they noticed a change in the emotional atmosphere at home. They felt more accepted and cared for.

CONCLUSION

The results of the study confirm the assumption that psychology students are able to conduct effectively a therapeutic intervention that involves the families of schizophrenic patients. The distinct advantage of such a project is that by non- and semi-professionals such as psychology students the self-help potential of the families is stimulated. As the student therapists cannot be considered as experts who solve the problems, the families are confronted with the necessity of taking the initiative themselves for any kind of change. By a project like the one described above, the transfer of research findings to clinical practice can be accomplished.

REFERENCES

Brown, G.W., Birley, J.L.T., and Wing, J.K., 1972, Influence of family life on the course of schizophrenic disorders: a replication. Br. J. Psychiatry, 121:241.

Buchkremer, G., and Fiedler, P., Angehörigentherapie bei schizophrenen Patienten, in: "Psychotherapie in der Psychiatrie", H. Helmchen, M. Linden, and U. Rüdiger, eds., Springer, Berlin-Heidelberg-New York (1982).

Fiedler, P., Christoph, S., Karntz, U., and Buchkremer, G., Das Münsteraner Ausbildungskonzept "Erwachsenenpsychiatrie", in:

"Neue Konzepte der klinischen Psychologie und Psychotherapie", E. Biehl, E. Jaeggi, W.K. Minsel, R.v.Queckelberghe, and D. Tschenlin, eds., Steinbauer & Co., Munich (1982).

Vaughn, Ch., and Leff, J.P., 1976, The influence of familiy and social factors on the course of psychiatric illness: A comparison of schizophrenic and depressed neurotic patients. Br. J. Psychiatry, 129:125.

COPING WITH SCHIZOPHRENIA IN DEVELOPING COUNTRIES:

A STUDY OF EXPRESSED EMOTIONS IN THE RELATIVES

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INTRODUCTION

The study of Expressed emotions (EE) ows its origin to the efforts of Brown and his colleagues in London during the last two decades to understand the family environment of schizophrenic patients. It has been shown in a series of studies that the expressed emotions of the key relatives, measured in an interview shortly after the patient's admission to hospital is highly predictive of the patients' subsequent course of schizophrenic illness. Brown, Birley and Wing (1972) found that EE rating scales are useful tools in quantifying emotional interaction in the family when a schizophrenic family member is admitted to hospital. In a replication study, Vaughn and Leff (1976) followed up the patients for nine months after discharge from the hospital. They found a significantly higher relapse rate in those patients returning to homes with high EE relatives as compared to those living with low EE relatives.

An opportunity came to study the emotional interaction in the families of Indian schizophrenic patients at Chandigarh when the WHO study on 'Determinants of outcome of severe mental disorder' was initiated in 1978, at the Department of Psychiatry, Postgraduate Institute of Medical Education and Research, Chandigarh. The objective of this project was to explore the applicability and validity of this technique in the Indian cultural setting, and to verify the hypothesis that relapse episodes in schizophrenic patients will occur more frequently in patients living in high expressed emotion families.

METHODOLOGY

Two catchment areas were selected for this study. One was the urban area of Chandigarh with a population of 383.500 and the other was a rural area having a population of 95.933, both as of March 1978. All the patients of first onset psychosis having first lifetime contact with any of the medical facilities in the catchment areas during the period from October 1978 to March 1980 constituted the universe. The patients were examined using past and personal history schedule (PPHS) and clinical assessment was made using the Present State Examination (Wing, Cooper and Sartorius, 1974). ICD-9 was used for diagnostic purposes. All the patients diagnosed to be suffering from schizophrenia were considered for inclusion. Patients living alone were excluded. The patients whose relatives did not cooperate for 'expressed emotion' (EE) interview were similarly excluded. The patients who could not be traced after the initial contact with the medical facility also had to be excluded.

This being a replication study, interviews were conducted with key relatives using the Hindi translation of the Camberwell Family Interview (CFI) developed by Brown and Rutter (1966), Rutter and Brown (1966) and Vaughn and Leff (1976). The interviews were tape recorded and ratings were made on five scales of Critical comments, Hostility, Emotional Overinvolvement, Warmth and Positive remarks, based on the criteria developed by these investigators.

ADAPTATION AND APPLICATION OF EXPRESSED EMOTION METHODOLOGY

All the narrative questions of the CFI were translated into simple spoken Hindi. The translated draft was tried on 11 Hindi speaking relatives of schizophrenic patients. Some of the English words like "nagging" and "grumbling" were difficult to translate in Hindi, which were reworded taking local expressions of these emotions. The list of household tasks was modified keeping in view the culturally assigned tasks to the male and female members of the north Indian families.

Two investigators from the Chandigarh Centre were trained by the staff of MRC Social Psychiatry Unit, Institute of Psychiatry, London. One investigator visited London and received the training at MRC Social Psychiatry Unit, while the second investigator was trained at Chandigarh when a staff member of the MRC Social Psychiatry Unit visited Chandigarh for this purpose. The training consisted of listening and rating of five EE scales the audio recorded interviews of relatives of English patients in the English language. Following this, reliability exercises were undertaken. One investigator (DKM) made blind EE ratings on 10 English recorded interviews, while the second investigator (HB) rated 9 interviews. Close agreement (more than 90 %) was observed on the ratings given

by both the investigators as compared to 'master' ratings on all the five EE scales. The second reliability exercise consisted of rating interviews in Hindi language on 7 relatives of Indian schizophrenic patients. Again close agreement was observed between the ratings of these two investigators.

OBSERVATIONS

A total of 103 patients were included in this study, 72 patients belonged to the urban area and 31 patients came from the rural area. Males and females were equally represented in the sample. Majority of the patients came from the younger age groups up to 29 years of age. Half of the patients were married. In the rural sample majority of the patients were married as would be expected as people in the rural areas marry at a younger age (Table 1).

Table 1. Sociodemographic characteristics of the patient sample

	Urban	Rural	Total
SEX			
Male	36	13	49
Female	36	18	54
AGE			
15 . 24	41	14	55
25 . 34	21	9	30
35 +	10	8	18
MARITAL STATUS			
Never married	42	9	51
Married	30	22	52
TOTAL	72	31	103

Interviews were conducted with the 'key' (close) relatives of 103 schizophrenic patients using the Hindi version of Camberwell Family Interview schedule by either of the two investigators (DKM and HB), within two weeks of the patients first lifetime contact with the medical facility. On several occasions, interviews were held with more than one relative, however for the purpose of this paper, the relative who scored higher on either critical comments, hostility or emotional overinvolvement was taken. Thus EE ratings were made on recorded interviews of 103 relatives of 103 schizophrenic patients at intake level. These patients were followed up for clinical course and outcome. Interviews with the same relatives were repeated at the end of one year, using the Hindi version of CFI by either of the two investigators (DKM and HB). In case of

relapse with exacerbation of psychotic symptoms in the patient, interviews with the relatives were held within two weeks of the relapse episode occuring anytime during the period of one year follow-up. Thus EE ratings were also made on one year follow-up interviews, which were possible in 89 relatives of 89 patients who were available for follow-up.

For the purpose of this paper, data on critical comments and overall rating of 'high' EE score are reported. Using the criteria of Vaughn and Leff (1976) a relative was rated having 'high' EE, if he obtained 6+ scores on critical comments and 3+ scores on the six point scale of Emotional over-involvement. Table 2 shows the mean scores on critical comments given by Indian relatives as compared to those reported by Brown et al. (1972) and Vaughn and Leff (1976). Mean scores on critical comments and frequency of 'high' EE are comparatively less in the Indian relatives (Tables 2 and 3). At one year follow-up very low scores were obtained on these two dimensions.

Table 2. Cross cultural comparison of average number of critical comments

Study	No of key relatives	Mean critical comments
Brown et al. (1972)	126	7.86
Vaugn & Leff (1976)	46	8.22
WHO Centre, Chandigarh intake data	103	1.92
WHO Centre, Chandigarh one year followup data	89	0.96

Table 3. Cross cultural distribution of high and low EE families

Study	High	Low	Total
Brown et al. (1972)	42 (42%)	59 (58%)	101 (100%)
Vaughn & Leff (1976)	21 (57%)	16 (43%)	37 (100%)
WHO Centre, Chandigarh intake data	20 (19.4%)	83 (80.6%)	103 (100%)
WHO Centre, Chandigarh one year followup data	7 (7.8%)	82 (92.2%)	89 (100%)

Table 4 shows the relationship between outcome and critical comments at one year follow-up assessment. Mean number of critical comments were higher in the relatives of the patients who relapsed or continued to remain ill during the period of one year follow-up. Similarly overall rating of EE was higher in these relatives (Table 5).

Table 4. Relationship between outcome and critical comments at one year follow-up

S/N	Outcome State	N	Total Number of critical comments	Mean
1	Complete or nearly complete recovery	66	40	0.6
2	One or more relapses with complete or nearly complete recovery with no marked personality change	6	12	2.0
3	One or more relapser with marked personality change	3	8	2.6
4	Continuous psychotic illness	7	17	2.5
5	Outcome not known	7	9	1.3
	TOTAL	89	86	0.96

Table 5. Relationship between outcome and overall rating of EE at one year follow-up

S/N	Outcome state	N	No of high EE families	%
1	Complete or nearly complete recovery	66	1	1.8
2	One or more relapses with complete or nearly complete recovery with no marked personality change	6	2	33.3
3	One or more relapses with marked personality change	3	2	66.6
4	Continuous psychotic illness	7	1	14.7
5	Outcome not known	7	1	14.7
	TOTAL	89	7	7.8

Tables 6 and 7 show the relationship of outcome at one year follow-up with critical comments and EE ratings obtained at intake asessment.

Table 6. Relationship between critical comments at intake EE assessment and outcome at one year follow-up

S/N	Outcome State	N	Total Number of critical comments	Mean
1	Complete or nearly complete recovery	66	140	2.1
2	One or more relapses with complete or nearly complete recovery with no marked personality change	6	5	0.8
3	One or more relapses with marked personality change	3	7	2.3
4	Continuous psychotic illness	7	29	4.1
5	Outcome not known	7	4	0.5
	TOTAL	89	185	2.1

Table 7. Relationship between overall EE rating at intake and outcome at one year follow-up

S/N	Outcome State	N	No. of high EE families	%
1	Complete or nearly complete recovery	66	14	21.2
2	One or more relapses with complete or nearly complete recovery with no marked personality change	6	0	0.0
3	One or more relapses with marked personality change	3	1	33.3
4	Continuous psychotic illness	7	2	28.5
5	Outcome not known	7	1	14.3
	TOTAL	89	18	20.2

DISCUSSION

This is perhaps the only study on expressed emotions done in a developing country. It is also the only study of its kind done on first onset schizophrenic patients longitudinally followed up over a period of one year. It has been possible to report only small part of the data generated by this study. As detailed

statistical analysis is under progress, the remaining data will be reported shortly.

The present study demonstrates that it has been possible to adapt and apply the expressed emotion methodology in a developing country meeting the scientific prerequisites of inter-rater reliability. The translated version of CFI in Hindi worked satisfactorily as the relatives expressed emotions could be rated on all the five EE scales of critical comments, hostility, positive remarks, warmth and emotional over-involvement.

Data show that critical comments and overall EE are less in the Indian relatives as compared to their counterparts in the London studies reported by Brown et al (1972) and Vaughn and Leff (1976). This is most likely due to the cultural differences in the manifestation of expressed emotions. This being the only study done in a developing country, it will not be possible at this stage to generalise the finding. Secondly, this might be due to the fact that data on EE scales in the London group of studies was obtained in the relatives of patients who had long standing illness, while on the present study the patients were of first onset.

Data presented in Tables 4 and 5 lend support to the findings of the London investigators that critical comments and EE are significantly higher amongst the relatives of patients who show a relapse or continue to remain ill. However, the London data does not clearly specify whether high EE is due to chronicity in the patient per se or the bad outcome is due to the high EE in the relative, as EE assessment was made only at one point in time and the outcome in the course of 9 months was correlated with retrospective assessment of EE. In the present study, it is possible to examine this relationship. The data in Tables 4 and 5 indicate the prevalence of high EE amongst the relatives when the patient is in a state of relapse or continuous illness. This finding is understandable as one would expect high EE in relatives when the patient is in disturbed state. When the clinical outcome at the end of one year is correlated with EE ratings at intake, as shown in Tables 6 and 7, the relationship does not emerge strongly enough to clearly support the hypothesis that high EE in the relative contributes to bad outcome in the patient.

The relationship is weakened by the fact that very few patients relapsed or continued to remain ill in the course of one year follow-up. The mean score of critical comments at follow-up assessment is much lower in the relatives of patients who recovered as compared to the relatives of the patients who relapsed or remained continuously ill. In view of this, it is indicated that high EE status in the relatives is reflective of symptomatic status in the patient. From the available data, the hypothesis that EE per se has pathogenic contribution to the psychiatric status of the patient could not be

confirmed. The alternative hypothesis would be that psychiatric status itself contributes to high EE in the relative. Further, prediction regarding course and outcome of the illness in the patient cannot be made solely on the basis of EE assessment made in the relative at intake level.

In the course of time, there is definite decline in critical comments and high EE ratings in the total sample cohort. This may be due to the fact that 66 patients out of 89 recovered, and only 10 cases (11,2 %) out of 89 showed relapse or remained continuously ill. Amongst the group of relapsed cases (N = 3), there was only one case of high EE at intake which increased to two cases of high EE at one year follow-up assessment (Tables 5 and 7). While in the group of continuously ill patients (N = 7), at intake assessment of EE, two relatives showed high EE, which was reduced to one case of high EE at follow-up assessment. In view of this, it may be said that the relationship between high EE and outcome is not yet clear. Perhaps longer follow-up and having a larger group of relapsed cases would be necessary to settle this issue.

The EE study at Chandigarh has provided extensive experience of understanding psychopathology in the families of schizophrenic patients in a developing country. Family abnormalities are important, and the search for better indicators in the family life determining course and outcome of the schizophrenic illness must continue.

The method of rating EE is cumbersome. The ratings are based on tonal fluctuations in voice. Training mental health workers in developing countries on these EE scales is very costly and time consuming. There is a need to develop simpler instrument for rating emotional interaction in the families which can become a part of clinical assessment. Perhaps, in the near future it will be possible to develop a short and practical method of predicting outcome in schizophrenic patients.

SUMMARY

It was possible to adapt and apply expressed emotion methodology in a developing country reliably. Critical comments and overall rating of EE were observed to be less in the Indian relatives as compared to their counterparts in London studies. Mean critical comments at follow-up were significantly higher amongst the relatives of patients who showed a relapse or continued to remain ill, which supports the findings of London investigators. Data suggest that high EE status in the relative is reflective of symptomatic status in the patient. The hypothesis that EE per se has pathogenic contribution to psychiatric status in the patient could not be confirmed. Prediction regarding course and outcome of the illness in the patient could not be made on the basis of EE assessment scores at intake as very few patients showed relapse. Application of EE

methodology in a developing country is costly and time consuming. It is recommended that short and practical methods should be developed to predict outcome of schizophrenic illness.

References

Brown, G.W., Birley, J.L.T. and Wing, J.K., 1972, Influence of family life on the course of schizophrenic disorders: a replication. Brit. J. Psychiat., 121: 241-258.

Brown, G.W. and Rutter, M., 1966, The measurement of family activities and relationships: a methodological study. Hum. Relat., 19:241-263.

Rutter, M. and Brown, G.W., 1966, The reliability and validity of measures of family life and relationships in families continuing a psychiatric patient. Soc. Psychiat. 1:38-53.

Vaughn, C.E. and Leff, J.P., 1976, The influence of family and social factors on the course of psychiatric patients. Brit. J. Psychiat.,129: 125-137.

Wing, J.K., Cooper, J.E. and Sartorius, N., The measurement and classification of psychiatric symptoms, Cambridge University Press, Cambridge (1974).

PSYCHIATRIC EPIDEMIOLOGY SINCE THREE YEARS AFTER RETIREMENT

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The brutal and definitive interruption of professional labour has only been known within the last century in industrialised societies and originally concerned mainly the most exhausting trades or those demanding constant attention and precision.

It appears, for World Health Organisation experts, that "for most workers, retirement constitutes a traumatic stoppage of the rythm of normal life which often leads to social alienation"*. The retiral of increasingly younger layers of the population still full of vitality, accentuates the contradiction between the potential of those active individuals and the conditions of life of a retired person.

Many factors, the biological ageing process, socio-economic conditions, the psychological factor lead social status to possible "social death".

Psychological factors play a preeminent role : An impoverishment of affective life, a decrease in the possibilities of adaptation, responsible of the tendency to withdraw from life interests.

Originally, retirement was conceived in order to spare those workers worn out by laborious or dangerous work. After the second war, the generalisation to include all categories of workers led geriatricians to question the benefits of such a rupture in activities assumed up to that point without any excessive suffering or notable danger.

I. Two principal theories

Amongst the currently prevailing theories on the question of

* La Santé Publique en Europe, in La Gérontopsychiatrie dans la Collectivité n° 10 - 1981 - 1981 - OMS p 100

retirement, two models predominate, one the antithesis of the other.

1. The "rupture" theory emphasises the capital importance of work as the agent of social integration. The retired person finds himself with his social position devalued and his time unstructured. His leisure activities are only a dull reflection of his past activities. His life has lost its sense of social usefulness.

The identity crisis creates a total perturbation of the personality which manifests itself through anxiety, depression,.... According to this theory, a decided increase in the mortality rate occurs after the age of 65 years. The conviction in a degeneration of the state of health is shared by numerous geriatricians, but so far no definite link can be shown between retirement and the increase in the mortality rate.

2. The continuity theory doesn't envisage retirement as contradictory to working life. Professional investment isn't exclusive for many individuals with different areas of social reference. Retirement doesn't arrive unforeseen and the role of the retired person is well thought out and prepared long before the moment of retirement. The shock of retirement frequently spoken of appears to be based more on some clinical cases than on statistical studies. Retirement, according to this theory, doesn't induce morbidity or a significant elevated mortality rate.

Undoubtedly, theses two theories only take into account part of the known facts.

Other variables, such as the socio-economic level have to be taken into consideration in order to explain the selection of one of these models :

- the higher socio-economic categories, according to ATCHLEY (1977) survive the retirement rupture more easily because of their involvement in work of a higher level and their real interest in their professional role.
- certain inferieur socio-professional categories are equally disadvantaged because of fewer possibilities socially, financially, in terms of relationships and of health, even though their desire for retirement is stronger than the management class with a higher professional level (ATCHLEY, 1977). Their principal preoccupation, realistically, concerns the financial aspects of retirement. The principal disappointment of retirement is the fall in income (SHEPPARD, 1976).

II. The study conducted by J. Ph. BUTAUD and J. DAHAN in 1982 was carried out in order to sift out the indices of psycho-mental health based on a sample of 1500 members of the population of the National Workers Retirement Centre (C.N.R.O.) which takes in a retired population of 900,000 allocatees from modest backgrounds, divided between rural and urban zones.

The method used was that of a questionnaire filled in by the investigator at the home of the retired person, worked out on the basis of the Sickness Impact Profile (S.I.P.) of Washington Univer-

sity. Five indices of psycho-mental health were set :

- speech
- intellectual alertness
- emotional control
- sociability
- morale (Berkman's index)

1. Speech difficulties are very rare. Amongst the recently retired population, 1,7% state that they "struggle to find their words" or articulate badly, 0,9% have real difficultiy in participating in a conversation.

2. Intellectual alertness is estimated on the basis of eight indicators : not finishing what one has begun, getting confused and undertaking more than one thing at a time, reacting slowly to the spoken word, having difficulties in reasoning or in taking decisions, making more mistakes or being more clumsy, being unable to fix attention for lenghty period, forgetting recent events and suffering from spatial or temporal disorientation.

Recent memory loss is the change most frequently noted : 48% (34% to a small degree and 14% to a high degree). This deterioration seems linked more to the general level of education than to age.

On the other hand, spatio-temporal disorientation is for the most part a result of age, with two gradations at 70 and 80 years. It affects widows and widowers, even the young, more than, couples.

3. Emotional control : this category includes pessimism with regard to the future, nervousness and agitation, irratibility towards oneself, sudden outbursts of laughter, sudden fears, a feeling of uselessness, a tendency to complain.

Pessimism and nervousness are very common, the more serious problemes affecting only 4%.

4. Social interaction measuring the tendency to withdraw displays some "less serious" and very widespread behaviour and some "more serious" but less frequent behaviour.

Thus estimated, sociability seems to be poor for 1% of retired persons and appears to be only to a small degree linked to age. On the other hand, it is better in the medium sized towns.

The tendency to leave home less, to shorten the length of or to avoid visits is most in evidence - apart from serious caharacter problems. This tendency to withdraw is influenced by celibacy or widowhood rather than by having had children.

5. Depressive tendencies : the use of the modified BERKMAN index shows that the feeling of solitude is little linked to the place or type of habitation, with the exception of Paris where it is very marked. Above all, it is affected by widowhood and living alone, which doubles the occurence of this phenomenon. More than half of those questionned felt lonely during the year following widowhood or separation. This feeling then very gradually decreases, affecting after three years of separation 40% of the population of widows and those separated.

Depression amongst the population studied does not depend on

age, and affects one retired person in seven (for those 85 years old and over, it represents 17,3%).

Town dwellers (from towns of more than 100,000 inhabitants), especially those from large cities like Paris are affected to a greater degree (23,5%) than those from the country (less than 100,000 inhabitants, 13,5%), those from the east (24,4%) more so than those from the North (7,1%).

Residence in an apartment is more likely to induce a feeling of depression (18%) than in an individual house (13%)

The principal factors of depression are, like with the feeling of loneliness, caused by the human environment : living alone (23%) widowed (22%) childless (19%).

There is a correlation between the feelings of loneliness and the depressive state with solitarity or agressive behaviour which constitutes the sociability index.

Very high degree of sociability	High degree of sociability	Mediocre sociability	Unsociable	
11.6	27.6	48.9	100	depressed
19.7	35.4	42.6	100	often alone

Besides the characterised depressive moods affecting one retired person in seven and almost a quarter of retired people from Paris and the East, positive appraisals have been expressed by more than one retired person in three, who states he is "completely" happy, "full of energy" or "full of interest" in life.

Hope and fear overlap each other, creating nuances within the replies.

BERKMAN's Moral index constructed on the basis of the preceeding data leads to the conclusion that about 20% of retired people have a low or very low morale. During the first few years of retirement, the morale of the retired person remains stationary. It has a tendency to decline progressively after 68 years. Living in a rented apartment is less favourable compared to privately owning an individual house.

Life in the Paris region and in the East of France is more often accompanied by a low morale as an indicator of deterioration of sociability.

For women, the most important factor is widowhood, especially during the first two years following the death. The work of the mourning process is accomplished afterwards.

Women have a morale decidedly lower than men. They are half as numerous as men in the "very high morale" category, and four times more numerous in the "difficulty in living" category.

III. Other Study : F. CLEMENT

Other studies, such as that of Fernand CLEMENT on ederly people from the electric and gas industries *, which investigated around 1200 individuals, have arrived at the conclusion that there is no pathology directly relevant to the retired person :"Health of elederly is worse when persons are older in all spheres : subjective appraisal, the number of past illnesses, the number of current ailments, consumption of medical or pharmaceutical products, "ageing" score, etc...". He concludes that passing to retired life is generally well accepted since only 1/5 of men and 1/3 of women have difficulties (including health problems).

IV. Morbidity and Mortality Indicator

Hospitalisation only affects the most serious cases : 98% of health problemes are treated outside hospital. Thus in 1973 there were around 2,250,000 hospitalisations for 143,330,000 visits and consultations. These last figures were obtained from investigation carried out for the European Institute for Documentation and Research into Illnesses (I.D.R.E.M.) based on a sample of around 1750 doctors practising with private clientele. This investigation constitutes a very interesting source of statistics on morbidity.

Out of 100 selected sick people, the following has been noted with regard to health problems.

age	45 - 54	55 - 64	65 - 74	75 - 84	85 and over
male sex	1.9	1.4	1.2	1.4	1.6
female sex	1.7	3.9	3.4	3.0	2.3

(Source : Ministry of Health 1977, reproduced by the Directory of social and sanitary statistics 1981).

The breakdown of initial diagnosis given by general practitioners in the course of consultations and visits, according to sex and age (in thousands) :

	sex	all ages	%	50-54	55-64	65 and over
mental problems	M	1519	3.2	3.7	3.6	2.9
	F	2840	4.5	5.6	5.1	4.3

On reading this data, there doesn't seem to be a decided

* In Gérontologie et Société n° 23-1982 p 92-135

increase in the frequency of mental problems for the male sex at retirement age or in the years following retirement.

With regard to women, a clear increase in the frequency of hospitalisation after the age of 55 years, and above all in the age range of 55 to 64 years is worthy of a closer analysis of the causal factors ; the completion of this study shows clearly that stoppage of work is not the only factor involved.

With regard to the medical consultations carried out by the general practitioners, this increase in frequency of mental problems of women does not occur (at retirement age).

V. Attempts at synthesis

As has been shown by the various studies previously analysed, retirement does not appear to be in itself a risk factor, even if the retired person is frequently depressed or presents various somatic troubles. The position of the non-retired person doesn't seem to be any better. It doesn't seem therefore to be the factor which is responsible for an aggravation of problems.

1. The synthesis carried out by J. POITRENAUD, F. BOURLIERE and J. VALLERY-MASSON concerning "the consequences of retirement for health" based on numerous American Studies, those of BELL, MADDOX, PALMORE and their own, concluded that the idea of crisis or rupture put forward by numerous geriatricians with respect to the cessation of work has been far from being verified. It would not really seem to have been demonstrated that retirement in itself is responsible for unexpected somatic or psychological disorders in individuals of over 60 years.

2. The analysis of various other american studies carried out by S.H. ZARIT 51980) concludes that the experience of retirement does not correspond with sudden alterations in the feeling of well being or in physical health, despite the expectations and anecdoctes affirming the contrary. Most research indicates that there are few alterations following retirement (LOWENTHAL, BERKMAN and Coll., 1976 ; STREIB and SCHNEIDER 1971 ; SHEPPARD 1976).

In one of the major studies, 1/3 of the replies indicated that retirement proved to be better than expected with only a negligeable number who indicated that it was worse than expected (STREIB and SHCNEIDER 1971).

The idea that retirement leads to bad health results perhaps from the fact that many people are forced to retire because of bad health. American studies estimate that around half of retired people have not retired voluntarily. Whilst 1/3 are affected by obligatory retirement on grounds of age, the remainder give up work through bad health or because of the disappearance of their jobs (ATCHLEY 1977).

Depression, frequently suffered by elderly people, notably appears to an extent palpably equivalent in non-retired people as in retired people.

Many people go through a honeymoon period immediatly following retirement, during which they occupy their time with activities long since interrupted or enjoy leisure activities (ATCHLEY 1977). Generally this honeymoon period comes to an end and they have to make more pertmanent adjustment to the retired state.

Health plays a critical role in this long term adjustment. The individuals who are dissatisfied with retirement are generally those who are most often in bad health (SHANAS and Coll. 1968). For those in good health, satisfaction and a certain ambivalence are expressed at the same time. Most people say they are content to be retired, however at the same time they point out that they feel a lack of purpose, of stimulation or any other than mundane occupations.

On the whole, the importance of work for an individual, his income, his state of health and the possibility of a worthwhile alternative to work are the critical elements involved in adapting to retirement.

Many people would like to abandon the routine and drudgery of their work, but it is often difficult to find satisfying alternatives. For certain people, work is certainly a favourite occupation and the obligatory stoppage will be accepted with great difficulty.

Retirement has important consequences for marital relations. In particular, the equilibrium is changed in families where the husband worked and the wife remained at home. Elderly women often joke about having their husbands under their feet ; others directly express anxiety about the retirement of their husbands. Difficulties often occur after the honeymoon period which follows retirement. As a result, many husbands take up substitute activities which maintain the separation of household roles.

Prevention of difficulties in adjusting

Amongst a variety of possibilities, some of which put forward the merits of retirement in a radical manner, envisageing more flexible methods of a diminution or stoppage of work, depending on the capacities and wishes of the worker, we will mention here only two techniques which to us seem useful :

the use of the offices of "volunteers" in the United States, which represents an extension of voluntary work, putting the emphasis on the specific role of the retired in educative or assistance situation.

preparation for retirement : since eight years our own experience of preparation for retirement led us to prefer the formula of courses of three days, spread over a period of more than one year, permitting the newly retired to be followed up after the beginning of their retirement. This type of course has been shown to be more helpful for the retired person, in adapting to his new

social status than the short information courses without any follow up.

Those who benefit most from preparation of this kind are those whose psychic equilibrium, being more fragile, is threatened by the stress involved in the existential reorganisation of retirement, above all, when added to this fragility we have isolation and poor socio-economic conditions.

An interview is necessary prior to the course in order to evaluate the capacity of the individual for change, and to plan out the work of the group in consequence.

The work of preparation for retirement represents the possibility of considerable assistance for those individuals exposed to the stress of the rupture presented by retirement and who are likely to undergo a depressive development.

REFERENCES

ATCHLEY R.A. The social forces in later life : An introduction to social gerontology, 2d ed. BELMONT, Calif. : WADSWORTH, 1977

BELL B.D. Life satisfaction and occupational retirement : beyond the impact year. Int.j. Aging hum. Develop., 9, 31-50 (1978-1979)

BUTAUD J.Ph., DAHAN J. Vieillir au quotidien en 1982 Documents C.N.R.O. n° 54, 1-1983

CLEMENT F. Réflexion à propos d'une étrange forme d'optimisme. Gérontologie et société, 22, 45-55, 1982

CRIBIER F. Le passage à la retraite des salariés parisiens. Gérontologie, 26, 9-22

DELANOE J.Y., DERUFFEL L., DEVOVASSOUY-MERAK-CHI. La morbidité en clientèle privée en 1973. IDREM. Santé et Sécurité Sociale, statistiques et commentaires, 1977, n°4, tome A

GAYDA M., VACOLA G. La préparation à la retraite. Psychiatrie pratique du médecin, 39, 1982

GEORGE L.K. et MADDOX G.L., Subjective adaptation to loss of the work role : a longitudinal study. j. Grent., 32, 456-462, 1977

GOGNALONS-CAILLARD. Existe-t-il une pathologie liée à la prise de retraite ? Actualités Psuchiatriques 3-1977, 35-36

GUILLEMARD A.M. La retraite une mort sociale. MOUTON, Paris, 1972

I.N.S.E.E. Données sociales, 1981

I.N.S.E.R.M. Santé Publique et vieillissement, Paris, 1982

LOWENTHAL M.F., BERKMAN P. and Associates. Aging and mental disorder in San Francisco. JOSSEY-BASS SAN FRANCISCO 1967

O.M.S. La gérontopsychiatrie dans la collectivité. La santé publique en Europe n°10 - 1981

PAILLAT P. L'âge de la retraite. Gérontologie et société 23, 1982, 5-13

POITRENAUD J., BOURLIERE F., VALLERY-MASSON J. Conséquences de la retraite sur la santé. Gérontologie (Eds BOURLIERE F.) FLAMMARION, Paris 1982

Santé des personnes âgées. Secrétariat d'Etat chargé des personnes âgées 1983

SHANAS E. et Coll. Old people in three industrial societies. ATHERTON - NEW YORK 1968

SHEPPARD H.L. Work and retirement. In R.H. BINSTOCK and E. SHANAS, eds. , Handbook of aging and the social sciences. Van NOSTRAND REINHOLD, NEW YORK, 1976

STOKES R.G. et MADDOX G.L. Some social factors on retirement adaptation. J. Geront., 22, 239-333 (1977)

STREIB G.F., SCHNEIDER C.J. Retirement in Amùerican Society : Impact and process. Cornell UIniversity Press, 1971

ZARIT S.H. Aging and mental disorders. Free Press NEW YORK 1980

MASKED DEPRESSION AND ITS TREATMENT

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Masked depression has been described in 1957 by P. Kielholz. Its main clinical features are as follows :

Masked Depression appears in middle-aged individuals who have demanding professional responsabilities and thus, it is often described in Europ as : "Manager's Disease". The course of the disease develops in three phases which extend over several weeks or even, several months.

In a first phase, a certain irritability dominates the clinical picture : a manager apparently overworked, begins to loose control over his behavior with his collegues or subordinates. He becomes irritated over little things and finds it impossible to cope with ordinary problems, which he previously would have handled easily. His memory and intellectual functionning are impaired. He is aware of this, and is disturbed by it, which increases his anxiety. Little by little he looses his ability to exercise initiative, while remaining aware of his diminished efficacy.

With these feelings of failure, the second phase sets in. It is characterized by withdrawal and hypocondriacal complaints. Increasing fatigue and sleep disorder lead to more specific health concerns. These complaints are organized around gastrointestinal system : (anorexia, gastric pain, colitis), cardio vascular system: (palpitations, pseudo angina-pectoris, sensations of breething difficulty) and nervous system : (headaches and muscular spasms).

These psychosomatic complaints motivate the first request for medical help. At this stage, anxiety may be prominent as well as nosophobia. It is this phase which is usually understood today by the term "masqued depression".

The third and last phase is the actual depression, as indicated by the following classical signs : sadness, gloominess mixted with pessimism and a sense of hopelessness. The patient is overcome by feelings of inadequacy, insecurity and low self-estime. The future looks bleak, and the patient may experience suicidal ideation. The absence of remorse and guilt however indicates that the depression remains within the neurotic range. At this stage, the individual is totally unable to work. The most common picture is that of intense fatigue, followed by difficulties in concentration and an apathy which may lead to a total inability to act.

This is, briefly summarized, the clinical development of Masked Depression. Before discussing treatment, we would like to comment on certain nosological aspects and aetiological hypothesis regarding this disorder.

WHAT DO WE MEAN BY "MASKED" ?

In this clinical picture, the most striking feature is the lack of energy, the feeling of being exhausted. We might think of a car in good condition but which has run out of gas : everything works but there is no more energy. This concept is important because it permits us to differentiate clearly beetween "masked depression" and the regression which characterizes the begennings of dementia.

Next, we must consider the relationship beetween this lack of energy and fatigue. The latter does not precede the lack of energy, but rather, is its consequence, as it has been pointed out by many authors and more recently by D. WIDLOCHER. Thus, the origin of this lack of energy does not lie simply in a growing fatigue ; but it lies elsewhere. According to D. WIDLOCHER, A. PUECH and al., lack of energy could be connected with an impairement of the noradrenergic system, i.e. the Locus Coeruleus and its efferent central bundles, which are implicated in arousal and activation processes. These two concepts lead us to examine now "masqued depression" in comparison to other clinical forms of depression.

MASKED DEPRESSION IN THE NOSOGRAPHY

According to KIELHOLZ, who considers on a biaxial scale, somatogenic and psychogenetic factors in depression, Masked Depression is to be situated between "Neurotic Depression" and "Reactionnal Depression". The latter takes it's origin in a stressing, "traumatic" life event, more often unique, such as a relative's death, or

separation, geographical transplantation,organic disease etc... The links between the traumatic life event and personnality remains unclear ; but, according to a psycho-analytical hypothesis, a particular life event becomes "traumatic" psychologically when it reactivates the traces of first childhood's "anaclitic depression" (which follows the anxiety generated by the first separation). Neurotic Depression is related only to personnality traits. Masked depression could be due, as it has been observed by P. KIELHOLZ and C. ADAMS, to the association of a given personnality and multiple traumatic events which originate a permanent state of psychological tension. But let's add once again that all these situations could not account for the genesis of depressive symptoms, if special attention is not given to personnality features.

PERSONNALITY FEATURES

Let us consider now these personnality traits. One may, with M. FERRERI draw some valuable indications from the clinical picture. "In masked depression, patients usually are hyperactive, consciencious, scrupulous, involved to a high degree with professional activities ; they always try to reach new goals andhave trouble delegating responsabilities to others". It is well known that these socially highly performing workaholic individuals remain vulnerable because of the personnal image they conform to for themselves and for others. They have been described by several authors : personnality type III in respect to GRINKER's classification, to whom they are "cameleon individuals" who adapt to what is expected from them, hiding their own emotions and spontaneity behind intellectualized interpretations. WINNICOTT called them "wrong self" personnalities and describes them as inauthentic, superficial and cut-off from inner reality. Others call them "as if" personnalities to emphasize the fact that these individuals live as if they are really what they appear to be. But the most interesting attempt was made recently by O. KERNBERG in his description of "narcistic personnality". Narcissic individuals are these egocentric personnalities who feel the need to shine and succeed professionally with constant backup and approval. This desire can certainly lead to top social positions but, never fullfilled, remains unsatisfied. "The New Narcisse", as he is called in the media lacks empathy, remains superficial, only preoccupated with himself and his own success. He breaks down at the slightest frustration which he finds intolerable. Confusing "Self" and "Self-Ideal" with the ideal object with whom he identifies himself, he is totally incapable to tolerate the slightest failure, and he becomes exhausted by the continuous search for gratification from his environment . When the "imposing self" (according to KERNBERG) looses his good adaptation, then depression emerges. C. LASCH, in his book : "The Culture of Narcissism. American life in an age of diminishing expectations", gives this new personnality a sociological approach. Accor-

ding to him, in the contemporary world, gratification from work becomes weaker, and interpersonnal relationships, self representation and the fad for therapeutical cults become more important. Mass-Media, especially television have abolished the differences beetween image and reality, thus forcing people into the imaginary cult of the person. They impose the idea that "total satisfaction" is possible through consumption of goods, services, experiences of all kinds, especially sexual. The never ending expectation of total fullfilment leads to exhaustion of any desire and to depression. This ontogenically very archaic narcissism rendes the personnality more susceptible to psychosis than to neurosis and incitates us to put it among the so called "Borderline personnalities".

NEURO-PSYCHO-BIOLOGICAL HYPOTHESIS

The developments of fruitfull neurobiological research, in the recent years, allows to correlate some neurobiological mechanisms and psychological and clinical situations. One may consider that emotions take their origin in direct and symbolic signals and they combine new informations with ancient ones, which are kept as a mnemonic trace in the temporal lobe. A recent hypothesis by LIEBOWITZ implicates the rewarding system, whose hedonic action is mediated throught the liberation of phenylalanine (PEA), norepinephrine and endorphines. A feed-back mechanism is triggered by the accumulation of endorphins. The Locus C oeruleus and it's efferent ascending pathways to the cortex play an important role in the liberation of substance P, which antagonizes the endorphins. These mechanisms should be taken in account to understand how, from a psychological point of view, disarry, satiete and depression follow pleasure, euphoria and excitation.

TREATMENT

From what follows, one can easily understand the purposes of a treatment of Masked Depression. It will have to focus on two main targets : reduce the clinical symptoms with an adapted chemotherapy, on the one hand, and induce a change in personnality with a focal psychotherapy, on the other hand.

Antidepressants should be effective on the inertia, apathy and inhibition which dominate the clinical picture at the third phase. Monoamine-oxydase-inhibitors (M.A.O.I.) are of course good agents, but they have several counter-indications. Desipramine or any recent antidepressive molecules such as Nomifensin, Viloxazine or Amineptine can be used, twice dayly, with great benefit, eventually associated to an evening anxiolytic drug.

The goal of psychotherapy is not easy to reach. Psychoanalysis itself can hardly be indicated at this age and in these conditions, but focal psychotherapy, eventuelly initiated during a short hospitalization shall allow these individuals to reorganize their defense mechanisms and thus, reconsider some of their narcissic positions and adopt more realistic perspectives and more adapted behavioral patterns.

ACKNOWLEDGEMENT

We thank Lynn DEMING and Martine CHEVALIER for their kind editorial assistance.

REFERENCES

FERRERI, M., Eux les déprimés, in : Acta psychosomatica, 1980, Documenta Geigy, 207 p., Paris.

GRINKER, R., WERBLE, B., DRYE, R.C., 1968, The borderline syndrom a behavioral study of ego-functions, Basic Books, N.Y. USA

KERNBERG, O., 1967, Borderline personality organisation, J. Amer. Psychoanal. Assoc., 641-685.

KERNBERG, O., 1979, Les troubles limite de la personnalité, Ed. Privat, Toulouse, 277 p.

KIELHOLZ, P., 1973, Masked depression, Hans Huber Publishers, Bern, 306 p.

KIELHOLZ, P., ADAMS, C., 1981, Le noyau dépressif, in : Cahiers d'information du Praticien, 1, Roche Ed., 125 p. Paris

LASCH, C., 1978, The Culture of Narcissism. American life in an age of diminishing expectations, Norton, N.Y., U.S.A.

LOO, H., ZARIFIAN, E., 1982, Les antidépresseurs. Aspects biologiques, cliniques et thérapeutiques, Printel Ed., Roche, 475 p.

PUECH, A.J., LECRUBIER, Y., SIMON, P., 1979, Rôle de la noradrénaline dans les troubles de l'humeur, L'Encéphale, V, 507-519.

WIDLOCHER, D., 1981, Fatigue et dépression, l'Encéphale, VII, 347-351.

WINNICOT, D.W., 1960, Distorsion du Moi en fonction du vrai et du faux self, in : Processus de maturation chez l'enfant, Payot Ed., Paris

RELATIONSHIP OF DEPRESSIVE STATES WITH WORK AND THEIR TREATMENT

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The question of pathology centered on work, is made at every period of economical crisis. In 1929, MOSES has already remarked that "psychic effects are the most serious consequences of unemployment".

However, links between depression and work are not limited to pathology concerning unemployment. They are :

- Disorders linked to work conditions

Work itself can generate stress and it seems that work division could be dangerous because it leads toward a greater dissatisfaction. A good work environment and team cohesion would diminish the risks of stress.

Some socio-professional categories are liked to be more exposed. Thus, coal miners stress has been described, as well as in managers or medical doctors. Begoin has described a telephonists and typists syndrome, BEN SABBATS has written over stress situations in watchmen and airlines pilots.

- Disorders linked to unemployment

Dismissal leads to an insecurity feeling, lost of self-esteem and guilt sentiments, creating "The unemployed's anguish" as described by TABARY.

Nevertheless, rather than resounding illness, unemployment situations lead to increase masked depressions and alcoholism (LIBERT), without specific disorders (AMIEL).

- Depressive disorders linked to retirement

Passing from active life to retirement is resented by individuals as a risk situation, modification of social status leading to a real bereavement. Here again, there is an increase in frequency of depressive states and the pathogenous risk is greater in the case of anticipated retirement (FERRIERE).

In despite of the apparent cause, we will discuss the nature of depressive picture we have found.

GIUDICELLI distinguish 3 types of depressive states that dont move away from the usual frame of depression :

- He distinguish right away the "neurotic depressions" in those who are still capable to place themselves into a working existence.

- "Reactive or situational depressions" where unemployment is the essential cause of depression.

- Depression of melancholical type, where unemployment situation does not intervene as an etiological factor.

The research itself

We have proposed to appreciate the real incidence of problems linked to work as an etiopathogenic factor of depression and suicidal attempts.

This work concerns 524 consultations of the psychiatric service of Limoges CHU, -consultations requested by the emergency service-, from january 1st 1983 to may 31 1983.

The survey has been realized through a questionnaire that precises work status of patient, motif of consultation, and apparent causal valve of work problem.

The 524 consultations corresponde in the nosological plan to 85 % of suicidal attempts or depressive states :

288 women (55 % of consultations)
236 men (45 % of consultations)

We have gathered a 40 cases group where work seems to play a causal part in either depression or suicidal attempt. 24 of them concerned men (60 %).

Lost of work has been found in 8 % of cases, being invoked mostly by men (10 %), that by women (5,5 % of cases). Dismissal has been found to be the motive invoked by the majority of cases. There has been 36 cases of dismissal, 2 managers of little entreprises in bankruptcy and 2 cases of retirement or anticipated retirement.

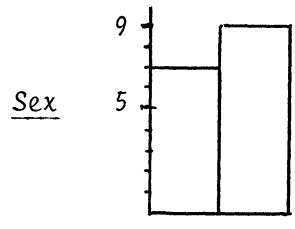
However, not all 40 cases corresponde to breakdowns where lost of work was a real etiological factor, thus, we have had exclude 24 cases where lost of work invoqued by the patient seemed to us a factor of secondary importance :

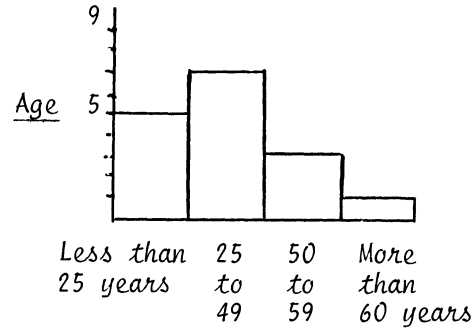
- psychopaths never stabilized in the same place,
- COTOREP petition already requested,
- lost of work linked to psychiatric problem (running away - resignation),
- ancient stoppage (more than 2 years).

In this way we have isolate 16 cases that corresponde to 3% of consultations. Considering the little number of isolated cases, it is difficult to make a precise statistical cleaning up of data. Nevertheless we must point out again that there has been 60 % of men cases and 40 % of womens'.

44 % of patients had already been hospitalized in a psychiatric service or have already commited a suicidal attempt. Pathological personality features have been discovered in 4 patients (3 neurotic personalities, 1 psychopatic personality).

CHARACTERISTICS OF THE 16 CASES RETAINED
AS AUTHENTICALLY LINKED TO A WORK PROBLEM





SOCIO-PROFESSIONAL LEVEL	
Without training	: 4
Industrial workers	: 5
Employees	: 6
Managerial	: 1

PSYCHIATRIC BACKGROUND

- Suicidal attempt
- Hospitalization

Existence	: 7
Absence	: 9

It seems like in this 16 cases sub-group, the sharing out corresponde to dismissal statistics in according to socio-professional category. There is also a quite clear predominancy of non-qualified or slightly qualified workers. Almost one third

of cases are less than 25 years old. We must say that into the framework of a psychiatric consultation at an emergency service, favoured place of observation for crisis situations, the incidence of work as pathogenic factor seems rather weak.

We have found in half of the cases, either psychiatric past history and suicidal attempt, either a pathological obvious personality.

DISCUSSION

1° We can discuss the exact part of work factor in depression genesis :

a) The sociological approach emphasize over the harmful nature of social organization in the development of depressive disorders. This would be just an aspect of "workers neurosis" as described by italian authors.

b) The psychiatric traditional approach favorize the individual, biological and genetic features and will only find in work the explication for a labeled reactive factor.

c) The approach through stress theorie will favorize harmful factors linked to environment, but created pathology corresponde rather to fatigue phenomenon and somatic manifestation and not to depression itself.

We have agreed to AMIEL's position : "There is not a specific disease of dismissal. It hapens to be a bereavement problem. The breakdown could be linked to subject's own history, efficiency of his defenses and fragility of his personality".

Work belongs then to a whole of causes that lead to breakdown and it is seldom an essential etiological factor.

2° Findings do allow us to conceive treatment :

- First of all, in the chimiotherapic classical aspect with taking care modalite and possible hospitalization.
- Besides, we must help the subject to analize either work or dismissal stress in the frame of individual history and own personality.

Finally, we must define psychiatrist place in this pathology linked to employment, as therapist as well as consulting medical doctor, in order to favorize :

- The psychological "working out" previous to retirement.
- The mental hygiene in workshops where social relationships could be very stressing.
- A more frequent examination of risky subjects, particularly psychopaths and neurotic personalities.

REFERENCES

1 - AMIEL R. - Psychopathologie du non-emploi - Prospective et santé, 1982, 23.

2 - BENSABAT S. - Stress - Hachette, 1980.

3 - BRENNER M. - Mental illness and the Economy - Cambridge, Mass : Harvard University Press, 1973.

4 - DEJOURS C. - Psychopathologie du travail - E. M. C., Paris, Psychiatrie, 37 886, A 10, 2 - 1982.

5 - DELIVRE J. - Crise économique et pathologie - Prévenir, 1980.

6 - FERRIERE R. - La psychopathologie du travail - Psychiatries, 1980, 41.

7 - JERVIS G. - Condition ouvrière et névrose - Théorie et politique, 1976, 51.

8 - LIBERT M., PAGER L., REGNIER J. M. - Chômage et santé mentale. La Croix Marine, n° 1, 1982.

9 - MARTIN , AUGER , CAVIGNAUX - Problèmes psychologiques des cadres au chômage - Santé mentale, 1971, 4.

10 - MICHAU A., KUHN F., PETER B. - Enquête sur le passage à la retraite - 1er Congrès francophone de Gérontologie, Masson, 1981.

11 - SELYE H. - The stress of life - New York, Me Graw - Hill Book Co, 1956.

12 - TABARY J. J. - Travail, chômage et Psychiatrie - L'information psychiatrique, 1979, 55, 3.

13 - THOMANN K. D. - Van schock zum fatalismes saziale und psychische answirkungen der Anbeitlösigheit - Ed par Ali Wacker, Campus, Frankfurt, 1978, 266 p.

14 - TURCOTTE P. et WALLOT H. - The psychic stress at work - Union med can, 1979, 108, 4.

AMINEPTINE, A FAST ACTING ANTIDEPRESSANT DRUG:

RECENT PHARMACOLOGICAL DATA

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The structural originality of the antidepressant amineptine (a dibenzosuberane nucleus onto which is grafted a long 7-amino heptanoic chain) has often been compared to the originality of its neuro-biochemical action mechanism (Malen and Poignant, 1972, Poignant, 1979).

All animal studies show that amineptine essentially acts as a powerful stimulant, liberating dopamine by the neuronal endings of central dopaminergic pathways, and as an inhibitor of the neurotransmission of dopamine uptake. An increase in the dopamine level in the meso-limbic and meso-cortical systems in the rat is characterized by an ED 50 of 10^{-8} M, while the IC 50 is only 10^{-6} M, corresponding to a mild inhibition of dopamine uptake by amineptine.

The inability of amineptine and its two metabolites in displacing specific ligand of serotoninergic, dopaminergic, and adrenergic receptors of rat brain membrane has already been signaled (Labrid, 1983). Recent studies undertaken by Garattini (unpublished observations) show that the H1-histaminergic, benzodiazepine, tricyclic antidepressant, and Gaba receptors may not be considered possible binding sites for amineptine and its 2 metabolites at 10^{-6} M. Effectively, 3H-specific ligands (respectively mepyramine, flunitrazepam, imipramine, desmethyl-imipramine and Gaba) are not displaced after an incubation of 30 to 220 minutes.

Scuvee-Moreau and Dresse (1982) utilising electrophysiological technics on anaesthetized rats noticed that the firing rate of dopaminergic neurons (neurons of the ventral tegmental area of mesencephalon, cell group A10) was preferentially reduced by an i.v.

infusion of amineptine. A 50 % reduction in firing rate was recorded for an average dose of 3,12 ± 1 $mg.kg^{-1}$, and the inhibition was reversed by the administration of haloperidol : this, then, confirms the dopaminergic nature of the synapses involved by amineptine infusion. Borsini et al. (1981) compared the aptitudes of amineptine to those of other substances in reducing the immobility duration of the rat swiming in a restricted space. Effectively, this test, proposed by Porsolt et al. (1979), not only revealed the potential of classical antidepressants (imipramine-like drugs) but also that of tetracyclic compounds such as mianserin or atypical ones such as iprindole. The results show that amineptine is active for doses ranging from 20 to 40 $mg.kg^{-1}$ (i.p.) and that its action is suppressed by penfluridol, a central dopaminergic antagonist. Thus, a cause and effect relation can be established between the neuro-chemical effect, seen in the central dopaminergic pathways, and the ability of amineptine to reduce immobility duration of the rat swimming in a restricted space. This relation is considered to be higly predictive of an antidepressant activity in human therapeutic.

Recent studies (in cooperation with S. Garattini, Mario Negri Institute, Milano) permit further exploration of the neuro-chemical action mechanism of amineptine. Using receptor binding assays of specific tritiated ligands in different rat brain structures, the effect of a chronic treatment of amineptine on the receptor densities of several neuromediator was investigated.

METHODS

Male rats weighing approximately 200 g receive intra-peritoneally a twice daily dose of 20 $mg.kg^{-1}$ of amineptine for 15 days. Three days after treatment discontinuation, the animals are sacrificed and their brains are quickly dissected and stored at -20°C until binding assays. These assays are made on crude membrane preparations obtained using the techniques of Bennet and Snyder (1976) and of Nelson et al. (1978).

In order to study dopaminergic receptor-binding the specific ligand utilized is the 3H-spiroperidol. It is incubated for 15 minutes at 37°C in an incubation buffer containing 5 mg of tissue (striatum). Non-specific binding is determined with (±) butaclamol.

When studying serotonin-binding, 3H-serotonin is utilized ; the tissue (hippocampus) is incubated under the same conditions as before, and non-specific binding is determined in presence of unlabeled 5-HT.

For ß-adrenergic binding the specific ligand utilized is 3H-dihydroalprenolol. The study is performed on the cortex ; non-specific binding being determined with (±) propranolol.

Binding parameters were calculated by Scatchard analysis from saturation experiments using 6 to 8 different concentrations of 3H-ligands.

RESULTS

The first table shows the data obtained when using only one ligand concentration. Chronic treatment of animals using amineptine caused a decrease of 3H-spiroperidol binding in the striatum and of 3H-dihydroalprenolol in the cortex. These decreases attained 71 % in the former case and 73 % in the latter. Nevertheless, hippocampus binding of 3H-5HT was not significantly modified.

Saturation curve analysis for these tritiated ligands showed that observed binding parameter decreases were due to changes in ßmax (corresponding to the quantity of receptors available for ligand binding) and had no effect of the KD value.

Table I

TREATMENT	Specific bindings of triated ligands (p mol.g^{-1})		
	3H-5HT (hippocampus) (18 nM)	3H-spiroperidol (striatum) (10 nM)	3H-dihydro-alprenolol (cortex) (6,5 nM)
Control group (Na Cl - 0,154 M)	5,38 ± 0,319	25,0 ± 0,79	7,2 ± 1,0
Amineptine (20mg.kg^{-1}, twice daily, i.p. route)	6,05 ± 0,32	19,2 ± 2,0**	5,27 ± 0,5**

** $p < 0,01$

each mean is calculated on 4 animals results

DISCUSSION AND CONCLUSIONS

This study shows that chronic treatment of the rat by amineptine (20 $mg.kg^{-1}$ i.p. twice a day for 15 days) causes a decrease in specific binding of 3H-dihydroalprenolol in the cortex and of 3H-spiroperidol in the striatum. These decreases respectively correspond to a decrease of ß-adrenergic receptors and of dopaminergic receptors in the cerebral structures studied.

It must be noted that all anti-depressants manifest the same neuro-chemical effect on the number of ß-adrenergic receptors. After a chronic treatment by imipramine-like drugs, IMAO's or other anti-depressants (iprindole, mianserine), the same effects can be observed. This is due, in fact, to the intense stimulation of noradrenergic pathways and must be correlated to the antidepressant activities of the compounds.

On the other hand, the simultaneous diminution of the number of dopaminergic receptors after a treatment using amineptine is unique : it corresponds to what we know about the dopaminergic action mechanism of this molecule. Now one must discover why a product, which doesn't act forcefully on the release or the uptake of noradrenaline during acute experimentation (for doses which exert a forceful effect on dopaminergic pathways) can at the same time modify the number of active ß-adrenergic receptors. Maybe there is interference between the reaction on dopaminergic and noradrenergic pathways. Maybe amineptine exerts a significant physiological effect on noradrenergic pathways after a chronic treatment even though nothing can be discovered during acute experimentation.

REFERENCES

Bennett J.P. Jr, Snyder S.H., Serotonin and lysergic acid diethylamide binding in rat brain membranes : relation to post-synaptic serotonin receptors. Mol. Pharmacol., 1976, 12, 373-389

Borsini F., Bendotti C., Velkov V., Rech R., Samanin R., Immobility test : effects of 5-hydroxytryptaminergic drugs and role of catecholamines in the activity of some antidepressants. J. Pharm. Pharmacol., 1981, 33, 33-37.

Labrid C., Pharmacologie de l'amineptine : nouvelles données sur le mode d'action. Psychol. Med., 1983, 15, 7-13.

Malen C.E., Poignant J.C., 7-amino-heptanoic derivatives as potential neuro-pharmacological agents. Experientia, 1972, 28, 811-812.

Nelson D.L., Herbet A., Bourgoin S., Glowinsky J., Hamon M., Characteristics of central 5-HT receptors and their adaptive changes following intracerebral 5, 7-dihydroxytryptamine administration in the rat. Mol. Pharmacol., 1978, 14, 983-995

Poignant J.C., Revue pharmacologique sur l'amineptine. L'encéphale, 1979, 5, 709-720.

Porsolt R.D., Le Pichon M., Jalfre M., Depression : a new animal model sensitive to anti-depressant treatments. Nature (London), 1977, 266, 730-732.
Scuvee-Moreau J., Dresse A., Effect of amineptine on the firing rate of central mono-aminergic neurons in the rat. Arch. int. Physiol. Bioch., 1982, 90, 371-375.

INTEREST OF A FAST-ACTING ANTIDEPRESSANT AGENT IN MAINTAINING A NORMAL ACTIVE LIFE (TALKING OF DEPRESSED PATIENTS TREATED AS OUTPATIENTS)

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INTRODUCTION

Maintaining a normal active life should be possible for the depressed patient, provided that his treatment is efficient and well tolerated. Thus, hospitalization can be avoided, social and professional activities can be carried on.

Therapeutic action should be rapid both on depressed mood and on retardation, which frequently impairs social performance. This therapeutic action should persist.

Acceptability should be excellent in order to obtain a good compliance from the patient ; the medication should not impair daily life by its side-effects, such as sedation.

Maintaining family and socio-professional life constitutes in it-self a helpful factor of recovery.

The aim of the present study is to determine whether amineptine* satisfies these conditions in long-term treated outpatients.

This study includes 62 outpatients who received amineptine during more than three months. They are among the 367 depressed patients who had been treated with amineptine during at least one month in a multicentered study in which 1354 patients were treated by 162 psychiatrists all over France (Deniker P. et al).

* Trade name : "Survector 100" - Laboratoires Euthérapie, 31 rue du Pont, 92200 NEUILLY SUR SEINE - France -

We can summarize the main points of the protocol of this multicentered trial as follows :

- Open study

- Inclusion criteria
  . 18 to 70 years
  . in or out patients
  . depressive disorder (I.N.S.E.R.M. French classification)

- Exclusion criteria
  . contra-indications of treatment with amineptine
  . pregnancy
  . serious organic diseases
  . previous recent antidepressant treatment

- 200 mg daily during 4 weeks or more

- Possible combination with other psychotropic agents

- Hamilton depression rating scale

- Side-effects

PATIENTS AND METHOD

The 62 patients, 41 women and 21 men, were all and from the beginning of the study, treated as outpatients.

Their mean age was 46,4 $\pm$ 1,6 years (range from 25 to 70 years)

Clinical diagnoses

. 7 melancholias were diagnosed (4 of them occuring in patients with previous manic disorders) ; the physicians had considered that it was possible not to treat these patients in hospital
. most of these outpatients (41 subjects) presented neurotic or reactive depressions
. 5 depressed patients had personality disorders (mainly antisocial personality)
. 9 of them presented schizo-affective disorders, or depressive disorders following acute psychosis.

Treatment

The patients were treated with a mean daily dosage of about 200 mg of amineptine, during a mean period of 139 $\pm$ 5 days (range from 90 to 270 days).

Amineptine was given alone in 3 % of the subjects.

It was associated to other psychotropic agents in 97 % of the patients : mostly benzodiazepinic anxiolytics, non-barbiturates hypnotics and from time to time neuroleptics.

Most frequently, there was combination of an anxiolytic drug and a hypnotic one with amineptine.

CLINICAL RESULTS

They will be discussed at once.

Clinical global assessment :

The clinical global assessment showed that
. 63 % of the patients had very good and good results
. 27 % of the patients had incomplete results, but were slightly improved
. 10 % of the patients failed to respond to the treatment

It is clear that only the patients who had been improved during the first weeks of treatment, kept on taking it as a long-term medication, and therefore were included in this study. This observation is confirmed by the results of the global assessment, which are markedly better than those of the multicentered study (1354 patients - 75 % of positive results) and than those of blind studies :
. versus amitriptyline (Van Amerongen P.),
. versus clomipramine (Lemoine P. - Porot M. et al),
. versus imipramine (Oules J. et al - Ropert R. et al),
. versus maprotiline (Bernstein S. - Jean-Louis P. et al),
. and versus trimeprimine (Vauterin C. et al).

The 6 therapeutic failures occured :

- in two patients whose treatment was eventually ineffective
- in two patients whose treatment was not enough effective to avoid hospitalization
- in two patients who relapsed on amineptine.

The 7 melancholic depressions were improved (6 good or very good results, 1 incomplete result).

One patient appeared "almost hypomanic" ; his psychiatrist could not decide whether this episode was induced by amineptine.

Withdrawals

Treatment had to be withdrawn in 4 patients :

- twice because of inefficacy
- twice because of relapse on amineptine

Acceptability

- The drug never had to be stopped because of side-effects

- The following psychic side-effect were reported :

  . slight excitement in 4 patients
  . increase in anxiety and inner tension in 4 patients (the associated treatment had to be changed in 3 of them)

- The following somatic side-effects were reported :

  . headache in 2 patients
  . digestive disorders in 2 others

Those side-effects have never been severe.

It was reported neither atropine-like effect, nor decrease of blood pressure ; amineptine did not produce drowsiness, nor sexual disorders.

DISCUSSION

The results of the multicentered trial (1354 patients - 75 % of positive results, with 52 % of good and very good results) had confirmed the efficacy of amineptine in the treatment of depression. This antidepressant activity had already been shown in many double blind studies, in melancholias and other types of depressions. The long-term evolution of the patients initially improved with amineptine, is the main point of this study involving 62 out-patients treated during more than 3 months. Only two patients, initially very improved at the beginning of the study, relapsed on amineptine. No subject but two had to be hospitalized. In most cases, maintaining treatment with amineptine, allows maintaining good therapeutic result, and avoiding hospitalization. Therapeutic result was maintained without any real change in the dosage of amineptine, neither during the first three months, nor later.
No patient increased the daily dosage on his own initiative. The only modifications observed were due to the psychiatrists.
The mean dosage prescribed was in most cases the dosage recommended by the manufacturer (200 mg daily), so were the associated medications (anxiolytics, sedative neuroleptics).

The rapid onset of the improvement, particularly of psychomotor retardation was often noticed, so that the patients could resume quickly their socio-professional activities.

The withdrawal of amineptine treatment induced no depressive relapse in most of the patients. However, in a few patients, this withdrawal had to be delayed :

. two patients showed a slight depressive relapse when amineptine dosage was really decreased

. 6 patients and their psychiatrists were reluctant to stop the treatment.

Because of its fast action, peculiarly on psychomotor retardation, and of its lack of sedative effect, amineptine seems to satisfy the conditions required by the treatment of depressed outpatients, and to enable them to have an active life.

REFERENCES

Bornstein, S. (1979)
Cross-over trial comparing the antidepressant effects of amineptine and maprotiline.
Curr. Med. Res. Opin., 6 : 107-110.

Deniker, P., Besançon, G., Colonna, L., Coudert, A.J., Danion, J.M., Dufour, H., Escande, M., Feline, A., Fontan, M., Gayral, L.F., Marie-Cardine, M., Olié, J.P., Porot, M., Pouget, R., Singer, L., Sizaret, P., et Tignol, J. (1982).
Etude multicentrique extensive de 1354 observations de sujets déprimés traités par l'amineptine.
Encephale, 8 : 355-370.

Jean-Louis, P., Evreux, M., et Vachon, A. (1978).
Etude contrôlée à double insu de l'amineptine et de la maprotiline dans le traitement des dépressions masquées en gastro-entérologie (abstract) in : "IInd World Congress of Biological Psychiatry, Barcelona, august 31 - september 6 : 118.

Lemoine, P., Achaintre, A., Balvay, G., Bonnet, H., Burgat, R., Carrier, C., and Perrin, J. (1981)
Double-blind trial of amineptine and clomipramine in the treatment of depression.
Curr. Med. Res. Opin., 7 : 234-240.

Oulès, J., et Boscredon, J.
Amineptine versus imipramine. Etude contrôlée à double insu.
Nouv. Presse Med. (à paraître).

Porot, M., Gerstner, C. et François, M.A.
Activité antidépressive de l'amineptine : étude contrôlée à double insu (1980).
Therapie, 35 : 733-742.

Ropert, R., Barte, H.N., Ostaptzeff, G. et Kamoun, A.(1982).
Etude des effets thymo-analeptiques et de l'acceptabilité de l'amineptine comparés à ceux de l'imipramine.
Encephale, 8 : 389-403.

Van Amerongen P. (1979)
Double-blind clinical trial of antidepressant action of amineptine.
Curr. Med. Res. Opin., 6 : 93-100

Vauterin, C., and Bazot, M. (1979)
A double-blind controlled trial of amineptine versus trimipramine in depression.
Curr. Med. Res. Opin., 6 : 101-106.

THE TRACE DETERMINATION OF AMINEPTINE AND ITS MAIN METABOLITE BY HPLC APPLICATION TO AMINEPTINE PLASMA LEVELS FOLLOWING ORAL ADMINISTRATION IN HUMANS

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ABSTRACT

An isocratic reversed-phase ion-pair liquid chromatographic method was used to determine amineptine and its main metabolite plasma levels. The main parameters of the analytical method were discussed.

Results obtained by this HPLC procedure were compared to those obtained by a GC/MS as reference method. The method was applied to the determination of the pharmacokinetic profile of the drug and its main metabolite during the clinical evaluation of amineptine in patients after oral administration. The sensitivity of the method will allow to follow plasma amineptine and its metabolite in human studies in the range 10 to 1000 ng/ml.

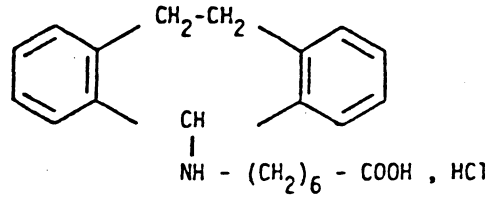
INTRODUCTION

Amineptine hydrochloride, [(dihydro-10, 11 5 H-dibenzo [a,d] cycloheptenyl-5) amino] -7 heptanoic acid, HCl is an antidepressant drug with dopaminergic properties showing no sedative activity (1-5). Amineptine presents 2 pka 4.5 and 8.7 corresponding respectively to the carboxylic group and to the amine group.

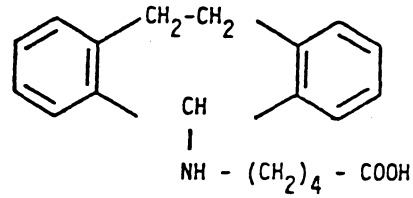
The biotransformation of the drug in man showed mainly a shortened amino acid side chain in blood (C_5 against C_7 for amineptine).

Up to now only a GC/MS procedure for plasma amineptine determination has been published (7-8).

The analytical method described below, which is an isocratic reversed phase ion-pair liquid chromatographic method was used for the plasma determination of amineptine and its main metabolite in humans.



AMINEPTINE, HCl



METABOLITE

MATERIALS AND METHODS

Reagents

Amineptine, its metabolite and internal standard [(dihydro-10, 11 5 H-dibenzo [a,d] cycloheptenyl-5) amino] -8 octanoic acid were provided by Institut de Recherche Servier, Suresnes, France. Standard aqueous solutions at 10 µg/ml of both amineptine and its metabolite on the one hand and of internal standard on the other hand were daily obtained from respectively 1 mg/ml stock solutions. The latter were prepared by solubilizing drugs in methanol using an ultrasonic bath ; they were stored at + 4°C in brown glass flasks and were found to be stable for at least one month. Acetic acid of rectapur grade, phosphoric acid and n-heptane of normapur grade, purified octanol were all obtained from Prolabo (Prolabo, Paris, France). Phosphate buffer (pH 7.0), acetonitrile and methanol of lichrosolv grade were purchased from Merck (E. Merck, Darmstadt, G.F.R.). The ion pair reagents, tetraheptylammonium bromide (THABr) and heptane sulfonic acid sodium salt were purchased from Eastman Kodak (Touzart & Matignon, Vitry-sur-Seine, France).

Chromatography

The chromatographic apparatus consisted of the following components : - a Waters model 6000 A pump (Waters, Paris, France) - a Pye Unicam spectrophotometer (Pye Unicam, Paris, France) operated at 220 nm - a Rheodyne 7125 injection valve (Touzart & Matignon, Vitry-sur-Seine, France) equipped with a 50 µl loop. The detector output

was connected either to a Kontron W + W 610 recorder (W.W. Electronic Inc., Basel, Switzerland) or to a H.P. model 3390 A integrator (Hewlett Packard, Paris, France) - a stainless steel column (150 x 4.6 mmi.d.) packed with a Nucleosil C 18 5 µm stationary phase (Macherey-Nagel, Düren, G.F.R.), using a slurry packing technique (9) with some modifications to the solvents used : the slurry was made with n-butanol and the packing solvent was methanol.

The mobile phase consisted of acetonitrile-distilled water mixture (38 : 62 v/v) ; The aqueous phase contained 1.2 g/l heptane sulfonate and was adjusted to pH 3.0 with phosphoric acid. The mobile phase was filtered using a 0.45 µm millipore filter and degassed in an ultrasonic bath. The separation was effected isocratically at ambient temperature.

Taking of blood samples

5 ml of venous blood samples were collectec into a 10 ml vacutainer green-stoppered tube (Becton-Dickinson, Missisauga, Canada) and centrifuged at 900 g. When the determination was not carried out immediately, the plasma was frozen at -20°C in plastic tubes ; in these conditions, no degradation of drugs was noted after one month storage.

Extraction procedure

2 ml of plasma were added to 1 ml pH 7.0 phosphate buffer, 100 µl of 10 µg/ml internal standard solution and 10 ml of heptane-octanol-THABr (98 : 2 : 0.5, v/v, W) in 10 ml Teflon-lined screw capped glass tubes.

The tubes were shaken for 10 minutes on a Laboral oscillating agitator (Prolabo, Paris, France) and then centrifuged at 900 g for 10 minutes. 8 ml of each upper organic phase were collected in a 10 ml conical base glass tube and 200 µl of a 0.17 M acetic acid-methanol (90 : 10, v/v) mixture were added. The tubes were capped and placed on a Breda Scientific rotary agitator (Bioblock, Paris, France). The shaking was carried out at 10 rpm for 5 minutes, and tubes were spun at 900 g for 5 minutes. The upper organic phase was discarded and 50 µl of acetic methanol phase were injected into the chromatograph.

Calibration curves and calculations

Plasma samples were spiked with increasing amounts of amineptine and its metabolite (final concentrations : 0.05, 0.10, 0.25, 0.50, 1.00 µg of each drug/ml of plasma) and with 100 µl of a 10 µg/ml internal standard solution. The samples were extracted by the previously described procedure and standard curves were generated for each series of determination, by plotting peak height ratios (drug/internal standard) versus known drug concentrations.

Plasma concentrations were interpolated from these standard curves. Accurate results were obtained using an integrator and calibration from a 0.5 µg/ml drug standard solution.

Linearity, sensitivity, selectivity

The standard curves were obtained by measuring the peak height ratios (drug/internal standard) on chromatograms obtained from drug-free plasma spiked with amineptine, its metabolite and internal standard. A linear response was observed when plotting peak height ratios versus concentration in the range 0.01 - 1.00 µg of each drug/ml.

The detection limit (signal/background = 3) was at least 0.01 µg/ml for each drug.

Selectivity was tested. The following drug gave no interference : Maprotiline, Amitriptyline, Chlomipramine, Oxazepam, Triazolam, Bromazepam, Levomepromazine. The following drugs could interfere : Lorazepam, Nitrazepam, Chlorazepate.

Reproducibility

Within day reproducibility was obtained by carrying out 8 determinations from plasma spiked with amineptine and its metabolite. Day-to-day reproducibility was determined over one month. The following results were obtained :

intra-day reproducibility,

Levels ng/ml	Amineptine (c.v. %)	Metabolite (c.v. %)
1000	2.0	2.0
250	3.2	2.5
10	8	12.0
day-to-day reproducibility, 250 ng/ml	4.4 %	8.2 %

Recovery

Five extractions were performed for 3 levels of drug concentrations (0.10, 0.50 and 1.00 µg/ml). The results were compared to those obtained for non extracted standard solutions, and expressed as percentage. The following recoveries were reached for amineptine and metabolite respectively : 64-73 % and 62-73 %.

CLINICAL APPLICATIONS

The HPLC method described allows to carry out routine monitoring of plasma amineptine and its metabolite in humans. No interfering peak from endogenous compound was detected at the retention times of 4.0 minutes for metabolite, 6.0 minutes for amineptine and 8.0 minutes for internal standard.

Both determinations by HPLC and GC/MS (12) procedures were done on the same plasma samples. The following coefficients of correlation were found for amineptine and its metabolite respectively : 0.993 and 0.957 (fig. 1 (a) and (b) where relationship between GC/MS and HPLC procedures was studied.

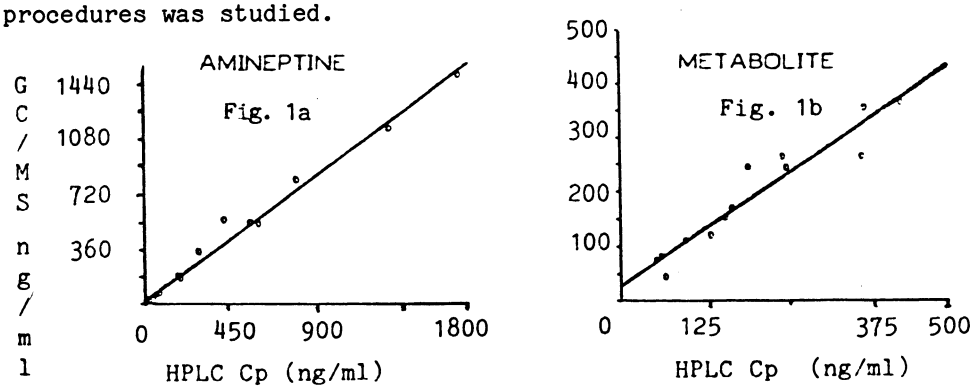


Fig. 1 - Relationship between GC/MS and HPLC plasma drug concentrations.

As a clinical application of the HPLC method (fig. 2 and 3) show the amineptine and its metabolite plasma levels found in two subjects. The depressant patients were administered 100 mg of amineptine hydrochloride orally once on the first and last days of administrations and twice daily on days 2-8.

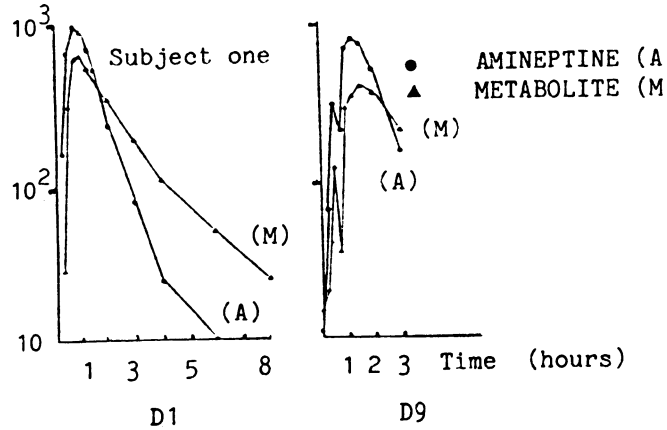


Fig. 2. Day 1 and day 9 amineptine and metabolite plasma concentrations depressant patient were administered 100 mg of amineptine, HCl orally once on the first and last days of administrations and twice daily on days 2-8.

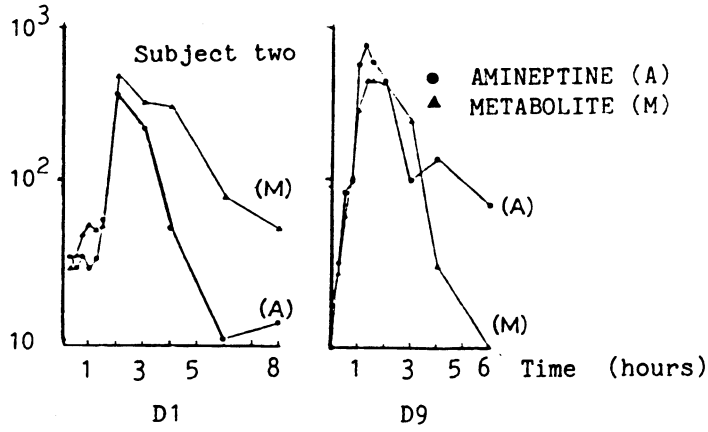


Fig. 3. Day 1 and day 9 amineptine and metabolite plasma concentrations despresant patient were administered 100 mg of amineptine, HCl orally once on the first and last days of administrations and twice daily on days 2-8.

CONCLUSION

An HPLC procedure was studied for the determination of amineptine and its main metabolite in plasma. The sensitivity of the method will allow to follow plasma levels in human studies in the range 10 to 1000 ng/ml.

REFERENCES

1) J.C. Poignant, l'Encephale, 5 (1979) 709.
2) M. Porot, C. Gerstner, M.A. François, Therapie, 35 (1979) 733.
3) C.E. Malen, J.C. Poignant, Experientia, 28 (1972) 811.
4) C.E. Malen, Psychol. Med., 11 (1979) 25.
5) R. Samanin, A. Jori, S. Bernasconi, E. Morpurgo, S. Garattini, J. Pharm. Pharmac., 29 (1977) 555.
6) C. Sbarra, personal communication.
7) C. Sbarra, P. Negrini, R. Fanelli, J. Chromatogr. 162 (1979) 31.
8) C. Sbarra, M.G. Castelli, A. Noseda, R. Fanelli, Europ. J. Drug Met. Pharmacokinetics, 6 (1981) 123.
9) B. Coq, C. Gonnet, J.L. Rocca, J. Chromatogr., 106 (1975) 249.
10) G. Schill, in J.A. Marinsky and J. Marcus (Editors), Ion Exchange and solvent extraction, Vol.6, Marcel Dekker, New-York, 1974, ch.1.
11) F. Smedes, J.C. Kraak, H. Poppe, J. Chromatogr., 231 (1982) 25.
12) P. Padieu & al. GC/MS amineptine currents results being published.

THE FATE OF PSYCHIATRIC PATIENTS AFTER DISCHARGE FROM STATIONARY THERAPY

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"The first year out" was chosen as the title of our symposium. It is the aim of this investigation to give a survey of one year in the lives of 258 people, who were admitted to a psychiatric hospital for the first time in 1979 and 230 of whom could be visited one year after their discharge and interviewed with regard to their fate in the course of this year.

We are indebted to the Deutsche Forschungsgemeinschaft for financial aid, without which this investigation would not have been possible. We hope to be able to repeat this investigation at the end of a 5-year period.

This investigation was held necessary because measures are discussed aiming at change and improvement in the fields of stationary, semi-stationary, and ambulatory psychiatric therapy and attempts are made to develop an optimal psychiatric-psychotherapeutic offer. In this effort not only personal experiences, which all of us have made, but also convictions, impressions, and opinions of one's own play a role, and these do not always rest upon secured empirical bases.

If we intend to improve the help offered to our patients - and nobody doubts the need to do so - it appears to be important to collect as many facts as possible discribing our patients' lives after their discharge from in-patient treatment.

Numerous hypotheses - some of them long known or continuously repeated - await being verified or falsified. Just at this point, there are many unanswered questions, such as: how do patients of different diagnostic groups rate themselves and their prospects

with regard to familiar, professional, and social reintegration? How do therapeutists, nursing staff, and relatives estimate the prognosis and whose judgement is the right one?

Which possibilities of professional reintegration do exist, and are there any relations between the pre-stationary and the post-stationary situation? Does the educational level possibly play a part?

How do the families experience the disease or psychic disturbance of their relatives and how do they react to it? In which manner do they feel themselves involved in this event or burdened? Do the patient and his relatives hold the offered help sufficient, especially during the post-stationary period, or do they need more extensive or different help? At which point of time should this aid begin? Are there any relations between the psychopathological symptomatics at the time of discharge and the further course of disease? Moreover, if readmittances become necessary, what is the cause, respectively?

This list of questions could easily be continued. In any case, the problem remains that we have to collect empirial data, if we intend to improve the possibilities of psychiatric care and follow-up care. The question how increase our therapeutic efficiency can only be resolved in continuous dialogue with the persons concerned.

Today, we would like to give a brief report on such a trial. It has to be mentioned that we are presently evaluating the results of the one-year catamnesis. The following reports allow an insight into this work, communicate first results, and open them for discussion. We hope to be able to repeat this investigation next year and then to survey a period of five years. Certainly, long-term catamnesis will prove to be a valuable tool in resolving a number of questions which could not be answered by short-term re-examination.

But already now many interesting and important results become apparant, some of which will be presented here. Before doing so, it appears to be necessary to describe the sample in detail upon which our investigation is based.

The analysis deals with 258 probands, who were included into a follow-up study concerned with pertinent questions of the professional integration and re-integration of patients undergoing their first psychiatric in-patient therapy. The sample comprises all patients who were first treated in the district hospital of Günzburg (Bavaria, government district of Swabia) between January 1 and December 31, 1979, and re-examined at the end of the following year (one year after being discharged). Not included were those

patients who had never been employed in a profession or whose employment dated long back when they were referred to the hospital. Patients to whom the question of professional reintegration could not (or only with great methodical difficulties) be applied, were also excluded. Therefore, the sample did not contain any probands over 60 years of age, unemployed persons, apprentices or "mere house-wives", no persons of foreign nationalities, and no patients with a diagnosis of "intellectual deficit".

With regard to socio-demographic and clinical features, our sample is characterized as follows: as far as the sex distribution is concerned our population consists of 165 (64 %) male and 93 (36 %) female patients. Their mean age was 35,9 years at the time of admission, ranging from 17 to 59 years. 128 (49 %) out of the 258 patients were married, 95 (37 %) unmarried and 35 (14 %) divorced, living separate from their partners or widowed, respecively.

With regard to school education, 11 patients (4 %) out of our population had got through ungraded classes or were without a completed school education. 202 (79 %) had finished elementary school, 17 (7 %) had finished secondary school ("Realschule", "Mittlere Reife"), 8 (3%) had passed high-school examinations restricted to certain subjects ("Fachhochschulabschluß") and 17 (7 %) patients had passed the final high-school examination.

As far as professional training is concerned, 91 (36 %) patients had no qualified training, 129 (51 %) patients had a qualified professional training, 13 (5 %) patients had passed examinations as foremen, 11 (4 %) had a restricted university training ("Fachhochschulabschluß") and 11 (4 %) were university graduates.

The distribution of professional positions shows that 17 (7 %) patients are civil servants, 62 (25 %) employees, 149 (59 %) workmen, 9 (4 %) independently working people, and 14 (5 %) assisting family members.

The distribution of diagnoses revealed 21 (8 %) patients with organically caused psychiatric diseases, 33 (13 %) patients with schizophrenic psychoses, 23 (9 %) patients with affective psychoses, 81 (31 %) patients with neurotic or psychosomatic diseases, disturbances of their personality or transitory psychic disturbances, and 100 (39 %) patients with a diagnosis of alcoholism or drug addiction.

The duration of in-patient therapy was 65,3 days on an average, 8 days being the minimum and 340 days the maximum according to the criteria for the selection of our sample.

At first, the methodical approach used in our follow-up study will be briefly presented, then we will report on the professional situation of our probands and its further course. The question will be dealt with, if the psychopathologic symptomatics allow any predictions with regard to professional and social reintegration. Some information will be given on the problem of readmittances, and, findly, attitudes and burdens of the family members will be discussed.

We are convinced that the material presented here is relevant and hope that the discussion of our first results will disclose additional aspects the consideration of which might prove to be fruitful in the further course of our investigation.

Summing up our present experiences, it appears justified to say that the old dualism between in-patient therapy on the one hand and out-patient therapy or - in certain cases - no therapy on the other has become obsolete.

Efforts will have to be made in the future to open up further possibilities of a stepwise transition between in-patient and out-patient therapy. Also, reintegration into professional life should not be an abrupt, but a stepwise procedure. Institutional aids in the form of an early rehabilitation have to be envisaged in any case and irrespective of the question whether a patient is in psychiatric in-patient therapy for the first time in his life or not.

It is important that, apart from the competent therapists, relatives, colleagues, and persons of the social environment are encouraged to participate in the process of reintegration and rehabilitation. Such a system of care, which is hitherto rudimentary, should be improved and completed. Possibly, this is the onset of a development that might be relevant also to other medical fields.

THE OCCUPATIONAL SITUATION AND ITS DEVELOPMENTS

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1. Introduction

The topic of this article is to answer the following question: to which extent first-admission patients were able, after their discharge from the psychiatric hospital, to take up or resume activities and functions which are generally regarded as particularly important or as basis functions (4) of everyday life. This study deals with the participation in professional life. The analysis of these activities refers to the first year after discharge. Thus we draw up a kind of 'short-term' prognosis for the occupational activities of first-admission patients and are able to elucidate the integration problems, psychiatric patients are confronted with at a relatively early stage of illness. In this context we also discuss the question to which extent chronic development can be identified at this stage of illness with reference to the permanent loss of certain role functions. The analysis reveals not only the seriousness of the problem, but tries to show at the same time in which fields help seems to be necessary and also possible. A wide spectrum of diagnostic categories was included in the investigation, as the results gained so far are mainly restricted to schizophrenic patients (1,2,5). Up to now other diagnostic categories have been brought in at most as control groups, and in doing so detailed information about the individual diagnostic category assigned to the control group are lost compulsorily. This implies the danger that other non-schizophrenic clinical problem groups are 'overlooked' and are therefore not supported to the same extent.

2. Method

To evaluate and quantify the degree to which the occupational role was impaired we investigated characteristics which try to reflect

the demands an employee is confronted with quite often and with regard to important aspects of the occupational role. Besides cross-section data such as the status of the employee at the time of follow-up, we also recorded longitudinal-section data which try to characterize the occupational development in the follow-up period. In detail, it is the number of jobs in the follow-up period (stability), the duration of employment (continuity), and processes of occupational progress and regress (vertical mobility). With regard to the individual aspects of the occupational role the scaling of the psychiatric sampling allows statements of the kind and degree of impairment in particular fields or particular life periods of the persons affected. For instance, they elucidate the question whether difficulties in meeting formal demands of the occupational role are restricted to certain aspects, e.g. to the ability to keep the occupational level or whether they are restricted to certain life periods, e.g. the time of follow-up. This procedure - we think - generates important information, but does not allow a quantification of the total degree of impairment or the total formal occupational reintegration. Such a statement, however, seems to be important for various reasons. On the one hand indexes contain more detailed information than the parts they are composed of (3); on the other hand they allow a scaling of all subjects, which is important for the posthospital situation in particular. For these reasons we developed a complex index by scaling certain combinations or patterns of measurements as measuring points on the index scale 'formal vocational integration' with regard to the characteristics defined above. We then obtained a scaling with six ranges which comprised the complex relations. The ranges reflect the extent of the patients' difficulties in meeting the demands which the status of employees implies.

3. Results

Of the 258 patients included in the original cohort, one-year follow-up data were obtained on 230 or about 90 %. Social and demographic data distributions of patients lost to follow-up were not significantly different from those on whom original evaluations were obtained.

3.1. Degree of Impairment with Regard to Individual Facets of the Occupational Role.

Continuity. The analysis of this facet revealed that in the course of the first year after the discharge only every third was able to resume his job and do it the whole year through without substantial periods of absence. One sixth had periods of absence up to a quarter of a year, and one sixth between 3 and 6 months. One sixth was not present at work between 6 months and almost the whole year. The remaining 18 % could not resume their job at any time of the follow-up period.

The diagnosis-specific analysis partly revealed clear differences between the diagnostic groups. Ss with the diagnosis of

schizophrenia, neurosis, or organic psychiatric illness had significantly more difficulties than the group of affective psychoses and above all the group of addicts. The addicts and the group of affective psychoses had significantly fewer periods of absence. The problem is elucidated by categorizing the periods of absence according to the pattern: no periods of absence; absence periods of up to a quarter of a year; absence periods of between 3 and 6 months; absence periods of between 6 months and a year. Most addicts and most patients of the group of affective psychoses (43 %) had been gainfully employed (continuously for the whole year). Only 20 % of these patients had periods of between 6 months and a whole year. In the groups of schizophrenic, organic or neurotic illnesses the proportions are reversed. Only 25 % of these patients did not have any periods of absence. 44 %, however, were absent from work for more than 6 months.

The analysis of the reasons the patients held responsible for their temporary or permanent absences of work revealed valuable background information about the kind and degree of difficulties in connection with absences of work. When asked which causes had led to absences of work the patients mainly mentioned unemployment and psychiatric illness (43 % for each cause). Clearly different proportions of absence reasons were revealed when the Ss were differentiated in "workers" (occasional absences) and "nonworkers" (permanent absence).

In the case of permanent absence, the psychiatric illness which had been treated was mainly held responsible (63 % of namings). Unemployment and other reasons were named significantly less. These proportions did not change if we took into account the duration of unemployment caused by sickness or other reasons.

Stability, Social Mobility, Status of Employees at the Time of Follow-up. The scaling of our sampling with regard to the remaining integration characteristics reveals the existence of further desintegration tendencies. For instance, over 25 % of the former patients - whose integration into business life was more or less successful - changed their job at least once in the first year after the discharge from inpatient treatment. The 230 analysed Ss had a notice rate of 110 altogether. The notice were mainly given after the discharge, partly, however, already in the course of inpatient treatment (81 % vs. 19 %). According to the patients, the employment was brought to an end,as a rule, by the employer or by "mutual consent" (66 % of the cases); in one third of the cases the patient himself was the initiator. As to the case mentioned first,the psychiatric illness played a decisive part in form of drop in efficiency (33 %), long absence (18 %), and stigmatization processes connected with the illness (10 %); these reasons were given by the patients. In the remaining 35 % of the cases other reasons independent of illness

were named (economic situation of the firm and others). In those cases in which the patient himself handed in his notice, the situation was somewhat different. About 50 % held their psychiatric illness responsible for the notice; fears of being stigmatized or actual stigmatization and the feeling that they were not able to cope with the demands at work on the long run were named as reasons in equal parts. In the remaining 50 % of the cases other factors not connected with the illness were mentioned (advancement wishes and others).

Irrespective of these problems and difficulties subjectively experienced in connection with the job situation after discharge, about 7 % of the total sampling were able to return to professional life only under the condition of a dequalification process. An examination of the job situation at the time of follow-up showed that the problems of our psychiatric patients had not changed at all after one year, because 25 % of the total sampling were still or again unemployed at that time. In reference to the great number of frequently useless attempts of reintegration into normal life, these data show the kind and extent of the difficulties first-admission patients were confronted with already in the first year after the discharge.

Concerning the stability of the job situation, the extent of the dequalification processes, and the job situation at the time of catamnesis, the diagnostic category the Ss had been assigned to was of no importance.

Consequently the impairments of these facets of vocational reintegration described had no statistically significant connection with the kind of illness which had led to inpatient treatment.

3.2. Degree of Impairment with Regard to the Total Occupational Role. The index comprising the complex relations describes more precisely and elucidates the extent of the problems by scaling the Ss with regard to the degree of impairment of the total occupational role. According to this, about every third of the former patients experienced a complete and - in our opinion - optimal reintegration.

This group has continuously had one single job without substantial absence periods and had not been subject to dequalification processes. Another 22 % were only impaired with regard to one or two facets/segments of the occupational role. Almost half of the patients, however, (48 %) showed medium to high degrees of impairment. Every fifth (18 %) of the total sample could not meet the demands which the status of an employee implies at any time of the observation period and dropped out.

As the patients of this group mainly mentioned the psychiatric illness as the reason for absence, we can deduce the statement that about every fifth of our patients showed tendencies to chronic development already at a relatively early stage of illness.

The diagnosis-specific analysis reveals different developments concerning vocational adjustment. Patients who were diagnosed

as schizophrenics had a clearly more problematic career when compared to the total sampling. The same results, however, are obtained with the group of organic psychiatric illnesses and the group of neurotic disorders. These three groups were clearly impaired in their role behaviour in comparison to the addicts and the group of affective psychoses. About every fourth (23 %) of the group of schizophrenic, organic, and neurotic illnesses experienced a complete or optimal reintegration. 16 % were impaired with regard to one or two facets of the occupational role. The majority (61 %), however, showed medium to high degrees of impairment. The group of affective psychoses and the group of addicts showed a clearly better role behaviour than the groups mentioned above, the difference only in the group of addicts being statistically significant. The majority of these two diagnosis groups, namely 2/3 (65 %), showed a relatively problem-free vocational reintegration. The remaining third showed medium to massive impairments, with the medium impairments in the form of absences of between 3 and 6 months predominating.

4. Summary and Discussion

On the basis of our methods we can see that in the first year after discharge even first-admission patients were confronted with problems in form of massive impairments in performing their occupational role. This is shown by index of formal vocational reintegration, which was developed by us. According to this general measurement about every third of the former psychiatric patients experienced a complete or optimal reintegration. 22 % of the patients were only impaired with regard to one or two facets of the occupational role. Almost 50 %, however, showed medium to massive impairments, whereby 18% of the total sampling dropped out completely. The tendencies described refer to problems which can react upon the persons affected and also upon the social system in many respects, unless they are adequately tackled. We mean that rehabilitative efforts have to be made much earlier than it has been practised so far. Rehabilitative efforts which are not granted until the failure is already obvious are often of little use. Furthermore, the results put the question whether the after-care given by institutions or other facilities were sufficient. At the same time they focus on the problem whether the social and mental health efforts of the social system proved to be useful and were sufficiently exhausted. In this context we think particularly of the possibility of resuming work step by step which none of our patients did. The demand for the legal regulation of partial inability to work which would enable the patient to get used to work slowly also leads into this direction. Instead, former psychiatric patients are still confronted with the demands of occupational life quite abruptly, are quickly overcharged, and give up their job early for fear of failure.

The diagnosis - specific analysis shows that the short-term prognosis of schizophrenia and also the organic psychiatric

illnesses and neurotic disorders had worse results in comparison to the course of affective psychotic illnesses and addicts. The question whether these results also apply to the long-term course is to be dealt with in a 5-year follow-up study planned for the year 1984. One thing, however, becomes clear already at the present: the occupational and social problems connected with psychiatric illness emerge already at a relatively early stage of illness. Accordingly, efforts must be taken relatively early to counteract these tendencies. In doing so, we must not forget that besides schizophrenic illnesses other clinical groups, above all the organic psychiatric illnesses, but also the neurotic disorders need this support to a larger extent.

REFERENCES

1. W.A. Anthony, G.J. Buell, S. Sharratt and M.E. Althoff, Efficacy of psychiatric rehabilitation, Psychological Bulletin 78:447 (1972).
2. J.C. Hall, K. Smith and A. Shimkunas, Employment problems of schizophrenic patients, Amer. J. Psychiatry 123:5 (1966).
3. F.N. Kerlinger, "Grundlagen der Sozialwissenschaften". Bd. 2, Beltz-Verlag, Weinheim (1979).
4. R. Schwarz und J. Michael, Zum Konzept von (psychischer) Behinderung, Nervenarzt 48:656 (1977).
5. J.S. Strauss and W.T. Carpenter, The prediction of outcome in schizophrenia. I. Characteristics of outcome, Arch. Gen. Psychiat. 27:739 (1972).

THE PROGNOSTIC VALUE OF PSYCHOPATHOLOGICAL SYMPTOMS FOR VOCATIONAL AND SOCIAL REINTEGRATION

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1. Introduction

The prognostic value of psychopathological symptoms for the vocational and social reintegration of mental ill persons after in-patient treatment in a psychiatric hospital is disputed in literature. Huber, Gross, Schüttler (1979), Paykel et al. (1978), Weisman et al. (1978), or the WHO-study of schizophrenia (1979) attribute a prognostic value for the outcome of psychiatric diseases to the psychopathological symptoms, whereas Ellsworth and Clayton (1959) or Ciompi et al. (1978, 1979) rather question this.

Attempts to explain these different results could be:

1. Only one diagnostic group or at least a restricted spectrum of groups were examined.
2. The patients' illnesses were at different stages.
3. The fields of social and vocational reintegration were either combined or only one aspect was examined.
4. The psychopathological symptoms were examined at different times.

This study tries to examine the influence of these problematic variables in a detailed way. There is a broad spectrum of psychiatric diseases. The patients are in the early time of their mental illness. The assessment of the psychopathological symptoms was made at discharge and one year later, because these symptoms impair the patients in their vocational and social life. Finally vocational and social outcome are assessed separately.

The aim of this article is to describe the relation between the psychopathological symptoms and the vocational and social reintegration of first-admitted patients, because these symptoms can only be described as impairments in the sense of Wing (1976)

or Schwarz and Michael (1977), when they actually have an effect on the daily life.

2. Instruments

The 9th version of the Present State Examination (PSE) by Wing et al. (1973) was used for the assessment of the psychopathological symptoms. The PSE was carried out both at the time of the discharge and one year later.

To quantify the social reintegration one year after the discharge, we developed a questionnaire, which is named Social Adjustment Scale (SAS) below. The questionnaire picks out the aspects of socially expected activities and free-time activities as central themes and is presented both to the patient and an informant, who lives closely to him. They received identical questionnaires to describe the present behaviour ot the patient.

The aspect of vocational reintegration was examined with a structured interview after one year, and the individual professional variables were combined to a total index of vocational reintegration. A detailed description of the procedure has already been given (cf. Vogel, same volume).

3. Results

Before dealing with the prognostic value of the symptoms for vocational and social reintegration, I would like to give a short review on the central results of the single variables to make a classification of the interrelations easier.

3.1. Psychopathological Symptoms. The distributions of the sum-scores for the psychopathological symptoms at the time of the discharge has a negative skewness, i.e. a high percentage of patients had only few symptoms when discharged.

The distributions change if the group of alcohol and drug addicts, the largest group (39 %), is excluded from this total group. At the time of the discharge this group shows hardly any psychopathological symptoms. Now the distributions of the remaining non-addicts has no longer a negative skewness, i.e. at the time of the discharge a great part of the patients showed many psychopathological symptoms.

This is corroberated by a test for the differences between the means of the various diagnostic categories. The differences between these groups are highly significant, and this can be attributed almost completely to the group of addicts. The other groups do not differ significantly.

One year after the discharge of the patients the results concerning the psychopathological status are similar. Again signi-

ficant differences between the diagnostic groups can be attributed to the group of the addicts. A direct comparison of the two times reveals differences. The frequencies on the both ends of the distributions increase, i.e. the proportion of patients without symptoms increases after one year, at the same time, however, the proportion of patients with many psychopathological symptoms increases. The significance test shows that the patients deteriorated significant on one of the two sum-scores, whereas significant changes could not be found on the other one. An examination of the changes at subscore level provides an explanation. The deterioration primarily takes place at the level of neurotic symptoms, but as the second sum-score deteriorates substantially only trough the increase of psychotic symptoms, no significant change takes place there.

The diagnosis-specific analysis of the data reveals that the patients with an organic psychiatric illness showed the significantly highest increase of their psychopathological symptoms. This applies both to the neurotic and the psychotic symptoms.

3.2. Social Reintegration. As mentioned in the description of the instruments, both the patient and an informant rated the patient's social adjustment one year after the discharge. Which rating of the behaviour should be used for the quantification of social reintegration - the patient's or the informant's?

Statistical analyses revealed that only in the groups of schizophrenic patients and addicts there were significant differences between the patient's and the informant's rating, in the sense of an overestimation of the extent of the social reintegration by the patient. On the grounds of these results the estimation of the informant was used as an indicator of the patient's social reintegration.

The diagnostic-specific analysis of these ratings revealed that the schizophrenic patients and the neurotic patients are the extremes concerning social reintegration, i.e. the informants of the schizophrenic patients rated the social adjustment significantly worse than the informants of the neurotic patients did.

3.3. Vocational Reintegration. I do not want to give a detailed description of vocational reintegration here (cf. Vogel, same volume). I would just like to mention again that in this field the addicts were the significantly best reintegrated patients.

3.4. The Prognostic Value of Psychopathological Symptoms for Vocational Reintegration. To judge the prognostic value of the symptoms for vocational reintegration, the total sample was divided into a group with poor reintegration and one with medium to good integration. Those patients who were employed in the course of the year after hospitalization for maximum 50 % of the time were described as poorly reintegrated. One third of the original sampling met this criterion.

The hypothesis that the psychopathological symptoms have a

negative effect on vocational reintegration could be approved for the total sample. The persons who were described by us as poor reintegrated showed significantly more psychopathological symptoms than the persons who were medium to well integrated, both at the time of the discharge and one year later. Can this result be found troughout all the diagnostic groups? This appears to be questionable for the mere reason that the PSE does not seem to be suitable as a prognostic instrument for addicts because of its low scores there.

The relations between the psychiatric status and the vocational reintegration are clearest in the groups of organic psychiatric diseases and neurotic patients. Patients with a poor vocational reintegration also have significantly more psychopathological symptoms at both times. In contrast, the poor reintegrated patients with a schizophrenic psychosis and addicts do not differ from the well integrated patients of the same diagnostic group with regard to the degree of their psychopathological symptoms. In the group of affective psychoses the relation between a high degree of psychopathological symptoms and poor vocational reintegration only exists one year after the discharge.

3.5. The Prognostic Value of Psychopathological Symptoms for Social Reintegration. Comparable to the vocational reintegration the sample was divided into one group of medium to well social integrated patients and one of poorly social integrated patients. Patients whose sum-scores on the Social Adjustment Scale did not exceed the lower half of the mean item-range were regarded as having experienced a poor social reintegration. This was the case with 1/3 of the original sample.

With our methods the hypothesis that psychopathological symptoms have a negative effect on social reintegration too, could be approved for the total sample only to a very limited extent. Only the psychopathological status obtained after one year showed clearly significant relations between the symptoms and social reintegration. There is only a tendentiously significant result that the psychopathological symptoms impairs the social reintegration at time of discharge.

Does this result characterize all diagnostic groups? As to patients with affective psychoses and neurotic patients the result is similar to that of the total sample. One year after the discharge the patients with a poor social reintegration showed a significantly higher degree of psychopathological symptoms than the patients with medium to good reintegration. The symptoms at the time of the discharge are of no importance for the social reintegration. No relations between the psychopathological results and social reintegration could be found in the groups of addicts and patients with an organic psychiatric disease. Only in the group of patients with a schizophrenic psychosis do the persons with a poor social reintegration show a tendentiously significant higher degree of discharge symptoms. The degree of symptoms after

one year is significantly higher in the group of schizophrenic patients who are characterized by a poor social reintegration.

4. Discussion and Summary

We could show that at the time of the discharge first-admitted patients - leaving out the group of addicts - partly show considerable psychopathological symptoms and that these symptoms do not recede after one year, but rather increase. If the influence of the psychopathological symptoms on vocational and social reintegration is to be described as determining, it is necessary to find relations between the symptoms at the time of the discharge and the data of reintegration. If i n a d d i t i o n a relation beween the symptoms after one year and social and vocational reintegration exists we have another indication of the impairing influence of the symptoms on reintegration. If, in contrast, e x c l u s i v e l y a relation between the symptoms after one year and reintegration is found, it is more likely that a poor vocational and social reintegration exerts a negative influence on the mental health of the former patient or that there is a close interaction between these two variables in the form of mutually influencing processes. The relations between the psychopathological symptoms and vocational and social reintegration are very different in the various diagnostic groups.

As to patients with an o r g a n i c p s y c h i a t r i c d i s e a s e the psychopathological symptoms obviously impair the vocational reintegration of the patients, whereas it does not exert an influence on the social reintegration.

The reversed result is obtained in the group of patients with an s c h i z o p h r e n i c p s y c h o s i s . Here the psychopathological symptoms, which were examined with the PSE, do not influence the vocational reintegration, but they impair the social reintegration significantly in the year after the discharge.

In the group of patients with an a f f e c t i v e p s y c h o s i s no significant relations between the discharge symptoms and the vocational and social reintegration could be found, but after one year patients with a poor vocational and social reintegration showed a higher degree of psychopathological symptoms. We can assume that a poor vocational and social reintegration impairs mental health or that a mutual influence exists.

Patients with a n e u r o s i s o r a p e r s o n a l i t y d i s o r d e r are characterized by the fact that the higher degree of symptoms at the two times corresponds with a poor vocational reintegration, i.e. the symptoms impair the vocational reintegration. In consequence of this poor vocational and mental state the patients show a social retreat.

Hardly any relations between the psychopathological results and reintegration were found in the group of a d d i c t s . This can primarily be explained by the fact the PSE is very restricted usefull for these patients.

The synopsis of the various diagnostic groups shows that the effects of the psychopathological status must be seen in strong dependence upon the investigated patient groups and the examined reintegration fields. Investigation approaches on a general level must lead to different results in this field, as was mentioned briefly in the introduction.

REFERENCES

Ciompi, L., Aguè, C. und Dauwalder, J.P., 1978, Ein Forschungsprogramm über die Rehabilitation psychisch Kranker. II. Querschnittsuntersuchung chronischer Spitalpatienten in einem modernen psychiatrischen Sektor, Nervenarzt 49:332.

Ciompi, L., Aguè, C. und Dauwalder, J.P., 1979, Ein Forschungsprogramm über die Rehabilitation psychisch Kranker. III. Längsschnittuntersuchung zum Rehabilitationserfolg und zur Prognostik, Nervenarzt 50:366.

Ellsworth, R.B. and Clayton, W.H., 1959, Measurement of improvement in "mental illness", Journal of Consulting Psychology 23, No. 1:15.

Huber, G., Gross, G. und Schüttler, R., 1979, "Schizophrenie. Eine verlaufs- und sozialpsychiatrische Langzeitstudie". Springer-Verlag, Berlin.

Paykel, E.S., Weissman, M.M. and Prusoff, B.A., 1978, Social maladjustment and severity of depression, Comprehensive Psychiatry 19(2):121.

Schwarz, R. und Michael, G., 1977, Zum Konzept von (psychischer) Behinderung, Nervenarzt 48: 656.

Weissman, M.M., Prusoff, B.A., Thompson, W.D., Harding, P.S. and Myers, J.K., 1978, Social adjustment by self-report in an community sample and in psychiatric outpatients, Journal of Nervous and Mental Disease 166: 317.

World Health Organization, 1979, "Schizophrenia. An international follow-up study", John Wiley & Sons, Chichester.

Wing, J.K., 1976, Eine praktische Grundlage für die Soziotherapie, Rehabilitation und Prävention schizophrener Erkrankungen, in:"Therapie, Rehabilitation und Prävention schizophrener Erkrankungen", G. Huber, Hrsg., Schattauer-Verlag, Stuttgart.

THE PROBLEM OF READMISSION

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1. Introduction

The problem of readmission to in-patient psychiatric treatment was examined in the past mainly with patients, who had previous admissions yet, the results of a great number of investigations proved to be contradictory. Some investigations (e.g. Viesselman, J. et al., 1975) see the diagnosis and the seriousness of the symptoms connected with the problem of readmission. Other studies (e.g. Jansen, D. & Nickles, L., 1973) do not find this difference. The question as to whether the readmission rate depends on the job situation also does not seem to be fully answered (e.g. Lorei, T. & Gurel, L., 1972). One of the few variables which were found as a predictor of a rehospitalization of psychiatric patients troughout is the variable 'number of previous admissions' (c.f. Rosenblatt, A. & Mayer, J., 1974). One reason why it was this variable that proved to be decisive can be seen in the fact that practically all investigations concerning readmission were carried out as retrospective studies. This result, however, has no practical relevance for measures which could prevent a chronic development or readmission after the first hospitalization. But results concerning the risk factors of readmission would be highly important for the psychiatrist at the time of admission. Such insights, however, can only be gained in a prospective study.

2. Methods

15 % of the 258 patients admitted for the first time to the 'Bezirkskrankenhaus Günzburg' (it is a total recording of the year 1979) were readmitted within one year. Apart from the interview at the time of the discharge, 33 of these readmitted patients could

be questioned one year after the discharge. The interview implyed questions on vocational and social reintegration and further on questions on the causes which led to readmission.

2 1/2 years after the discharge a second analysis was carried out. In these 2 1/2 years every patient had had the possibility of vocational and social reintegration. We have to point out that this analysis was not combined with an interview. The regular documentation of the 'Tagesberichte' (daily reports) and the files of our patients informed us about readmission at that time. Thus, we have the discharge interview data and the one-year catamnesis data of 65 patients (25 % of the total sampling).

Clinical variables such as 'discharge diagnosis', 'psychopathological symptomatic', 'prehospital development of illness', 'total duration of hospitalization', and 'legal justification of admission' were recorded. Furthermore, variables concerning the vocational aspects such as 'training', 'profession', 'duration of employment', 'net income', and 'unemployment' were taken into account, and sociodemographic variables such as 'age', 'sex', 'marital status', 'school education', and 'social class' were also included in the analysis.

3. Results

3.1. Analysis of Prehospital Variables.

The analysis of the data aimed at finding prehospital or hospital criteria which could provide information about a future readmission of first-admitted psychiatric patients at the time of the discharge. The surprising result was that only the variable 'discharge diagnosis' proved to be meaningful for a prediction of the readmission of the total group. The distribution of the diagnosis categories with regard to the readmission after 2 1/2 years is as follows:

TABLE I

distribution of discharge diagnosis	readmission after 1 year		readmission after 2 1/2 years		total population
	N	%	N	%	N
organ. psychiatric illnesses	6	28,5	7	33,3	21
schizophrenic psychoses	4	12,1	14	42,4	33
affective psychoses	5	21,7	6	26,0	23
neur. or psychosom. illnesses	10	12,3	14	17,2	81
alcohol and drug addiction	14	14,0	24	24,0	100
total	39	15,1	65	25,2	258 = 100 %

The most important result is the different distribution of the diagnosis categories: in the category 'schizophrenic psychoses' almost every second (42 %) and in the category 'organic psychiatric illnesses' every third (33 %) patient is readmitted after 2 1/2 years. Compared with the total group the risk of readmission is increased in these two groups.

The readmitted persons of the diagnosis groups 'affective psychoses' and 'alcohol and drug addiction' are unobstrusive with regard to readmission.

The group 'neurotic and psychosomatic illnesses' is the only diagnosis group which shows a low readmission rate. The question we had was: How does the percentage of readmitted patients change in regard to a different recording time? To put it another way: Are there other problem groups after 1 year when compared with 2 1/2 years after the discharge?

The most important result is the fact that the risk of readmission increases rapidly in the group 'schizophrenic psychoses'. Compared with the population of readmitted patients, the number of readmissions in this group was below the average at the time of the one-year catamnesis, but after 2 1/2 years it ranks at the top. The group 'organic illnesses' shows the opposite result: The majority of readmitted patients in this diagnosis category had been readmitted by the time of the one-year catamnesis. At both times the readmitted patients of this group are overrepresented when compared with the total readmitted sample.

The distribution of readmissions in the diagnosis category 'affective psychoses' is very similar. In this group too, the majority of the readmitted patients had been readmitted by the time of the one-year catamnesis and are overrepresented in comparison with the total sample of readmitted patients. Concerning the 2 1/2 years, however, this group of readmitted patients is up to the average.

The distribution of readmitted 'neurotics' is also interesting. At both times the readmission rate of this group is below the average. The diagnosis category 'alcohol and drug addiction' roughly represents the average of all readmitted patients at both times.

No significant results for the readmitted patients were obtained in an analysis of the vocational variables when compared with the persons who had not been readmitted. An analysis carried out specific to diagnosis, however, reveals a low level of prehospital professional training as the most important characteristic of the readmitted group of 'organic psychiatric illnesses'. Particularly persons who had no professional training are represented in this group. A deterioration of the prehospital professional qualification can be found in the group of readmitted 'schizophrenic psychoses' and the group of readmitted 'affective psychoses' is characterized by a decreased prehospital vocational integration.

Concerning professional parameters there is no noticeable

finding in the groups 'neuroses and personality disorders' and 'alcohol and drug addiction'.

3.2. Analysis of Posthospital Variables. As mentioned above, our population was questioned again one year after the discharge. Besides the clinical data, the data of the professional development within the catamnesis year was in the focus of our analysis.

Along with the psychopathological symptomatic variables such as 'difficulties with the discharge', 'problems at work', 'unemployment', 'illness', 'time of job resumption', 'knowledge of hospitalization in the psychiatric clinic', 'strain caused by the knowledge', 'subjective judgement of effiency at work' and a 'posthospital integration index' were recorded. The index 'vocational reintegration' includes variables such as 'actual duration of employment', 'periods of illness', 'change in qualification', 'status of employee', and 'number of jobs'.

Unlike the prehospital variables, a great number of posthospital variables are connected with readmission. The readmitted patients are for instance characterized by a decreased vocational integration (N = 65) and they show a higher degree of psychopathological symptoms.

The readmitted patients themselves frequently report of general difficulties after the discharge (e.g. difficulties with health, with themselves, and with the family), of problems at work, and of the inability to meet the demands of work (subjective judgement of patients). They also think that their successful return to professional life only succeeded with difficulties.

Like our procedure with the prehospital variables, an analysis specific to diagnosis was carried out with regard to the posthospital time. We found that vocational variables are connected with readmission as it was the case at the prehospital time.

The subpopulation of readmitted 'organic psychiatric illneses' is characterized by a decreased vocational reintegration and a high degree of psychopathological symptoms (PSE-data). The group of readmitted 'schizophrenic psychoses' could not keep the prehospital level and dequalified itself tendentiously.

The readmitted patients of this group also show a higher degree of psychopathological symptoms at the time of the catamnesis.

Compared with patients who had not been readmitted, the readmitted patients of the group 'affective psychoses' needed a longer time to resume work, and then felt that they could not cope with the demands of work.

In contrast to the prehospital time, variables concerning the vocational aspect become significant also in the two diagnosis groups of readmitted 'neuroses and personality disorders' and 'alcohol and drug addiction'. The vocational reintegration of the group 'neuroses and personality disorders' decreased. This is caused mainly by less working time and an increased number of job changes. The group of 'alcohol and drug addicts' also worked less and reported of problems at work.

3.3. Results of the Questionnaire for Readmitted Patients.

The interview of readmitted patients at the time of the one-year catamnesis focused particularly on the causes which had led to readmission, and on the questions as to how readmission could have been prevented and how far the first in-patient treatment was regarded as sensible.

The analysis revealed that psychiatric illness is the main cause of readmission for 46 % of the readmitted patients or a partly responsible cause for 67 % respectively. Thus, the illness which led to hospitalization is mentioned as the most frequent cause of readmission.

Problems at work or in connection with work were named on second position. 18 % of the readmitted patients regard them as the main cause and 54 % as a partly responsible cause.

Problems in the family were ranking on third place (18 % main cause - 36 % partly responsible cause) and on fourth place the non-observance of the psychiatrist orders or insufficient aftercare were named (6 % main cause - 30 % partly resonsible cause).

As a rule (85 %) the place of readmission was the 'Bezirkskrankenhaus Günzburg'. The treatment given is regarded as sensible by 43 % of the readmitted patients. One third (33 %) thinks that the treatment did not help, yet they do not think that it was unnecessary and one fourth of the readmitted patients say that the received treatment was useless.

Furthermore, over three quarters of all readmitted patients say, that the readmission could have been prevented.

One third of all readmitted patients consider an improvement of the clinical therapy as the main measure to prevent readmission, and 48 % consider it as an additional possibility. Such an improvement would imply a longer hospitalization when admitted for the first time, a better therapeutic offer of the hospital or better preparations for what 'awaits them outside', particularly a better preparation for the burdens at work. Another therapeutic variable, the improvement of medical aftercare, was named on second position. 28 % of the readmitted patients regard it as the main possibility to prevent readmission, 44 % as an additional measure. Another possibility of preventing readmission is a better support from relatives; 24 % regard it as the main measure, 36 % as an additional measure.

4. Summary and Discussion

The investigation of readmitted psychiatric patients aimed at answering the question as to which problem groups would have to be focused on to prevent readmission. We found that the discharge diagnosis was the only prehospital variable for the total group which could provide information for a prediction of future readmission. It was shown that 15 % of the original population had been readmitted within one year after the discharge and 25 % in

2 1/2 years. The risk of readmission is highest in the diagnosis categories 'organic psychiatric illnesses', 'schizophrenic psychoses', and 'affective psychoses'. Interestingly enough, the analysis specific to diagnosis revealed that these diagnosis categories show prehospital deficiencies in the professional field. If we consider these results in connection with the higher degree of psychopathological symptoms and the lower degree of vocational and social reintegration, we have to assume that these three groups were not able to cope with their prehospital professional handicaps.

Measures to support the vocational reintegration - for instance, by including the nursing staff - could have a clearly recognizable therapeutic effect in the cases of psychotic illnesses, above all in the first weeks after the discharge. Measures to support vocational reintegration seem to be of secondary importance for the two non-psychotic diagnosis groups ('neuroses' and 'alcohol and drug addictions'). With regard to social reintegration, support would be advisable in all diagnosis groups, because the readmitted patients judged themselves as socially decreased integrated, just as the persons to whom the patients is related to did. Here the largely unexploited potential of relatives could be included.

These supporting measures would not only correspond with the empirical results which were obtained but also with the wish of the readmitted patients for whom the most important measures to prevent readmission are an improvement of the clinical therapy and above all an improvement of the medical after-care and better support from relatives.

REFERENCES

Jansen, D.G. and Nickles, L.A., 1973, Variables that differentiate between single- and multiple-admission psychiatric patients at a state hospital over a 5-year period, Journal of Clin. Psychol., 29:83.

LOREI, T.W. and Gurel, L., 1972, Use of a biographical inventory to predict schizophrenics posthospital employment and readmission, Journal of Consulting and Clinical Psychology, 38:238.

Rosenblatt, A. and Mayer, J.E., 1974, The recidivism of mental patients: A review of past studies, Amer. Journal of Orthopsychiat., 44: 697.

Viesselman, J.O., Spalt, L.H. and Tuason, V.B., 1975, Psychiatric disorders in a community mental health center. II. Who gets readmitted? Comprehensive Psychiatry, 16:485.

THE PATIENT'S FAMILY: ATTITUDES AND BURDENS

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There are only few studies investigating the stresses in families of psychiatric patients and the way in which members deal with this problem. Studies performed so far do, however, agree that mental illness severely affects the family.

Willi (6) reports a host of physical illnesses in the family as the result of great emotional burdens caused by a schizophrenic person in the family.

Grad and Sainsbury (4) found that mental illness almost invariably means a deterioration in the family's economic standing. The authors have also shown that community centered care apparently increases the family's burden. Based on these considerations, we interviewed the relatives as part of an investigation of psychiatric patients who were admitted for the first time. Above all, we were interested in learning more about the effects of a person's illness on his family and recording, at a relatively early stage, the kind and extend of stresses in the family due to a psychiatric disease. Based on this information, concrete supportive measures can be developed at this early stage where the social conditions are not chronic and rigid, thus not hampering the success of these measures.

Methods

The relatives were interviewed one year after the patient's discharge, in most cases in the family's home. This 60-minute interview was carried out in the absence of the patient on the basis of a structured, pre-tested questionnaire developed by us.

Frequent, regular contacts between the relative and the patient, as well as the patient's consent were preconditions for an interview. The relative, moreover, had to be of age and was chosen, in most cases, by the patient himself.

230 patients were involved in the follow-up examination, and 179 relatives were questioned. Despite a drop-out rate of 22 %, these relatives represent without distortion the total random sample in regard to central examination variables. 50 % of the relatives interviewed were spouses, every fifth person questioned was a parent. Almost all relatives lived in the same house as the patient (91 %), and most of them shared an apartment with the patient. With a few exceptions (9 %), the relatives saw and spoke with the (former) patient daily.
The relatives interviewed were grouped according to the patient's diagnosis on discharge as follows:

10 % (n = 17)	organic psychiatric diseases
13 % (n = 24)	schizophrenic psychoses
10 % (n = 18)	affective psychoses
30 % (n = 54)	neuroses and personality disorders
37 % (n = 66)	addictions

Results

Two thirds of the relatives suffered from stresses due to the patient or his illness in the 12 months following his discharge. Half of them suffered from these stresses for the whole year. Every third relative experienced only the first few months (up to 6 months) after discharge as burdensome, while every fifth relative reported the occurrence of stresses only in the second half of the year after discharge (mostly alcoholics). We were then interested in determining different kinds of stresses, distinguishing between "emotional", "financial", "work-related", and "physical" stresses in regard to the relatives.

Stresses occurring were generally emotional; additional financial, physical or work-related stresses due to the patient or his illness were experienced to a much lesser degree (Table 1).

Furthermore, we know of 6 cases (3 %) where the relatives either had to stop working or go back to work; in 6 cases, the families had to apply for welfare benefits.

How can patients be described whose illness was a burden on their relatives in the 12 months following their discharge? Are there any characteristics typical of this problem group? Socio-demographic variables do not provide the information we needed to characterize the problem group; variables regarding illnesses and work were, however, quite suitable to distinguish this group from the group whose members had caused only little or no stress in their families.

Table 1: "Kind and intensity of stress appeared in the families of mental patients after their first hospital treatment"

n = 179

emotional stress/burden	66 %
severe - extremely severe stress	41 %
financial stress/burden	23 %
severe - extremely severe stress	9 %
work-related stress/burden	23 %
severe - extremely severe stress	9 %
physical stress/burden	16 %
severe - extremely severe stress	7 %

The relatives of patients with schizophrenic psychoses and organic psychiatric illnesses reported more often than others that stress existed in the family after the patient had completed in-patient treatment (88 % and 77 % of the corresponding diagnosis group), but the differences specific to diagnosis are significant merely as a tendency ($p = < 0.07$). Of the 5 diagnosis groups studied, the families of patients with neuroses and personality disorders reported the least occurrence of stresses (59 %). Relatives of patients with schizophrenic psychoses and organic psychiatric illnesses felt stress somewhat more frequently in the following year, but the stresses were not greater (intensity of stress) in comparison with the relatives of other diagnosis groups. Rather, it was found that the relatives of individual other diagnosis groups were subject to less stress in terms of quantity, which was, however, extreme; thus, e.g., relatives of patients suffering from addictions reported more frequently than others "extremely severe emotional stresses" (68% of this diagnosis group), relatives of patients with affective psychoses reported significantly more frequently than others "extremely severe stresses" due to extra work (42% of relatives of patients with affective psychoses).

There are other and - mostly - more important variables to classify stresses in the family besides the description of these stresses under diagnostic aspects: We found that stresses in the family occur especially when patients received frequent, regular out-patient follow-up treatment for their mental illness, and also when they were readmitted to hospital. Families of readmitted patients without exception reported stresses, mostly classified as extremely severe emotional stresses.

Rare, limited social activities of the patient in the family and in his spare time as well as his state of health are closely related to stress in the family. Besides these influences due to the illness, we also found a close correlation between the occurrence of stresses in the family after the patient's discharge

and work-related variables. Stresses occured particularly where the patient's return to work was felt to be problematic or regardes as a failure.

In view of these results, the question arises whether the relatives received support - and, if so, from whom - in coping with the stresses mentioned here. According to the relatives, every other family received help with their problems and stresses due to the illness-related problems and stresses for the one-year catamnesis period. In about every third family help was either not needed or not welcome, 16 % of the relatives would have appreciated help, but made no attempts to get help or did not know who to turn to. Support came mainly from the family itself (28 %). 15 % of the relatives considered the attending physician as helpful and supportive. In about every tenth family, friends helped to overcome problems and mitigate stresses. Relatively little support came from people in the working environment: colleagues (3 %) or superiors (3 %), pastors (3 %), psychologists or psychotherapists (3 %), employment offices (2 %), or the social services at the clinic (0.5 %).

Support was concentrated on families where problems and stresses had occurred in connection with the patient and his illness ($r = .54$), but there was by no means enough help available as to reach every family in this group and furnish support and help. In fact, support and help were available to only about every other family (54 %) suffering from extremely severe emotional stress and strain.

Every third family with heavy stresses had either not actively sought help (15 %) or did not know who to turn to (14 %). In cases where no help had been available in the year following the patient's discharge or where the relatives had wished for more help (37 % of all relatives questioned), we wanted to know from whom they had desired help: By far in first place was support and help by psychologists or psychotherapists, followed by the wish for help from within the family and the attending physicians. The strong wish for support from psychologists/psychotherapists (19 %) and social workers (7 %) is in striking contrast with support actually provided by these professional groups (3 % received support from psychologists/psychotherapists, 0,5 % from social workers).

Summary

It can be stated, in conclusion, that a mental illness in a member of a family means considerable stress in the family, not only as a result of chronic processes, but at quite an early stage. The stresses are not so much due to financial or work-related problems, but are emotional stresses and strains lasting for the whole year after discharge in half of the families. They affected families of all diagnosis groups, i.e. not only families of schizophrenic

patients literature has focussed upon. In this study, a close connection between the kind and extent of stresses in the family, on the one hand, and illness- and work-related variables, on the other hand, were found. Socio-demographic data, however, proved to be of no relevance, i.e. women were no more of a burden to their families than men, young patients no more burdensome than aged patients, etc.

We agree with other comparable studies in that a large number of families are let down by the medical and other professions at a time where they experience worries and are in need of help (1,2,3,5,7,). The family is still the central and vital system for providing support. Disregarding support from family and friends, we find that only about every fifth family received help from doctors, psychologists/psychotherapists, and social workers. A great discrepancy is found between the wish for psychological/psychotherapeutical help and the help actually provided in this sector.

This fact demonstrates needs which have so far been insufficiently met by the professions, in particular the need for relief by talking, recreation, and concrete measures to be taken by social workers in order to help the family to cope with their everyday problems. Given to the present situation, families cannot be expected - especially in the long run - to fullfill the task of rehabilitation.

REFERENCES

1. M.C. Angermeyer, Der theorie-graue Star im Auge des Psychiaters. Zur Rezeption der Wissensbestände der Familienforschung in der Sozialpsychiatrie, Medizin, Mensch, Gesellschaft 7: 55-60 (1982).
2. C. Creer and J.K. Wing,"Der Alltag mit schizophrenen Patienten", in: "Die andere Seite der Schizophrenie", H.Katschnig, Hrsg., Urban & Schwarzenberg, München (1975).
3. A. Finzen, "Psychiatrische Dienste und die Beeinflussung von Schlüsselpersonen in der Gemeinde", in: "Psychiatrie der Gegenwart", K.P. Kisker, J.-E. Meyer, C. Müller and E.Strömgren, Hrsg., Bd. III, Springer-Verlag, 297, Heidelberg (1975).
4. J. Grad and P. Sainsbury, The effects that patients have on their families in a community care and a control psychiatric service. A two years follow-up, Brit.J.Psychiat. 114: 265-278 (1968).
5. P. Krauss, Probleme der Angehörigen chronisch-seelisch Kranker, Der Nervenarzt 47: 498-501 (1976).
6. J. Willi, Die Schizophrenie in ihrer Auswirkung auf die Eltern, Schweiz. Arch. Neurol. Neurochir. Psychiatr. 89: 426-463 (1962).
7. E.S. Zolik, A. Des Lauriers, J.G. Graybill and T. Hollon, Fullfilling the needs of "forgotten" families, Am. J. Orthopsychiatr. 33: 176 (1962).

NEW CONCEPTS OF HOSPITAL PSYCHIATRY

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INTRODUCTION

The psychiatric reform movement of the past decades, developed four distinctive procedural categories, which we shall enumerate and comment upon as follows:

1. Abolishment of the psychiatric hospital - as demanded by the "Triest Model".

   This attempt proved abortive, partly because at the time it was put into operation, extra-mural care services hardly existed. Outside the psychiatric hospital therefore, the chronically ill patients were ostracized, degenerated into slum dwellers, and suffered deterioration of their psychic and somatic condition. The "Triest Model" demonstrated beyond doubt, that well-meant ideological concepts cannot alter the fact that discharge from hospital internment does not automatically constitute the cure of mental illness. Inside the hospital or outside its confines - the mental patient requires psychiatric treatment and care.

2. Departmentalization - i.e. the establishment of psychiatric departments (wards) in regional general hospitals, catering to the needs of approximately 30.000 to 40.000 local inhabitants.

   Establishment of many small departments in regional general hospitals, requires exact planning and considerable expediture, an investment which seems uneconomical in consideration of the fact that their restricted size precludes availability of an adequate range of diagnostic and therapeutic means, so that a super-imposed system comprising differentiating diagnostic and therapeutic tools,

as well as maximal care facilities for psychiatric problem cases, remains a necessity.

3. Sectorization - i.e. the establishment of psychiatric departments within the frame of central general hospital complexes, with a catchment area of about 300.000 to 400.000 inhabitants.

   This concept - frequently already effected through the existence of one or more psychiatric hospitals within a given area - appears nevertheless as a practical program, if certain conditions are catered to:
   a) an optimal regional distribution of such centralized institutions; - and
   b) psychiatric departments within the frame of these health centers would have to be structured so as to accomodate not only short-term treatment requirements, but also acutely psychotic cases requiring temporary confinement.
   Here again, we are confronted by the necessity for an extensive range of highly differentiated diagnosis and care facilities, enabling full utilization of psychopharmacological as well as non-medical psychotherapeutic treatment programs.

4. Inner reform of the psychiatric hospital - (in accordance with the sectorization principle) under utilization of the possibilities afforded by differentiation between acute and long-term treatment requirements and the requirements of long-term resident psychiatric hospital cases.

This paper intends to discuss a compromise solution based upon the factual situation regarding already existing psychiatric hospitals, under consideration of the resources at the disposal of public health agencies.

POTENTIALS AND LIMITATIONS OF INNER PSYCHIATRIC REFORM

Inner reform of psychiatry can only be considered as a realistic undertaking, if it is based upon three supportive pillars:
a) remodelling of the psychiatric hospital as such; -
b) concurrent establishment of adequately differentiated complementary care services; -
c) wide-spread publicity, in a form adapted to special regional circumstances.

In order to initiate implementation of a reform program and effect an outward opening of psychiatry, publicity must address itself to the decision makers (politicians) but also to hospital management and staff representatives (who, in the FRG for instance, have frequently signed responsible for the failure of reform programs) and finally, to the lay population in town and country.

In Austria for instance, psychiatric reform has been mainly of a directive nature. It was thus either instigated by gremiums concerned with hospital administration, or effected through certain, newly established service structures.

All reform programs however, are expected to provide adequate solutions for the elimination of pressing problems. Accordingly, the psychiatric hospital will have to accommodate to sectorizational requirements and both its size and internal structure will depend upon determining the extent to which individual psychiatric ailments demand differentiated short- or long-term treatment and care. Every reform program moreover, will need to orient itself upon scientifically researched rehabilitation principles also categorized by the time factor (i.e. early- follow-up- or late exposure to a suitable rehabilitative program.

One of the most fundamental and widely publicized questions concerns the suitable size for a psychiatric hospital. This aspect however eludes generalization and can only be determined individually and in consideration of the pertinent institution's requirements upon: a) the acute case sector; and- b) the long-term active treatment and passive patient care sector.

Within the acute psychiatric case sector, the following measures can be expected to reduce bed numbers:

1. Limitation of the in-patient treatment period;
2. Application of reformulated admission and discharge regulations;
3. Close collaboration with extra-mural care services and privately practising physicians.

Early hospital discharge should not however become a fetish, since its over-extended application frequently leads to a revolving-door psychiatry, because present day care services (on the psychiatric as well as on the social security sector) are not as yet sufficiently developed to effectively prevent recidivism in patients released from hospital in a convalescent state. Attention must in this connection also be paid to the fact that a diametrically opposite development, namely a tendency to increased bed requirements, has been observed during the past decade. It seems to have been caused by the formation of new service structures (f.i. adolescent and geronto-psychiatric care units);- the increased range of psychotherapeutic programs now on offer (which, as we have been able to prove at the Wagner Jauregg Hospital, has led to a general extension of the in-patient treatment period of more than 7 days);- and finally, to the rising number of therapy-resistent psychotic cases referred to in-patient treatment by physicians in private practice. Basically, our experience has shown that either tendency (a/limitation of in-patient treatment period and thereby bed reduction;- and b/extension of admission spectrum and therefrom increased bed requirements) tends to nullify the effect of the other.

In Austria, approximately 0,3 beds to 10.000 inhabitants constitutes a fair guide-line for organization of a psychiatric hospital's acute, short-term treatment sector,whereas 0,5 to 0,7 beds to 1.000 residents within the long-term treatment and care sector represent a good requirement average.

We are not as yet in a position to provide binding statements as to how many new admissions deteriorate into long-term cases despite intensive application of both pharmacological and psychotherapeutic treatment in the sense of an integrative psychiatry concept. Our statistics show that about 1 1/2 admissions per 100.000 inhabitants per year, will prove to become long-term hospital cases who will naturally occupy the appropriate care facilities.

The long-term care sector within an institution, previously denominated as "asylum" or "chronic patient's department" can be divided into two categories, by differentiating between rehabilitative patients and cases that demand surroundings of a nursing-home character. The possible discharge of long-term in-patients because they appear eligible and probably responsive to rehabilitative programs represents the most significant opportunity to effect a noteable reduction of bed numbers. Upon this very sector, we have been able, within a seven-year period, to reduce our in-patient numbers by nearly 40%. Such success naturally depends upon the availability of efficatiously organized extra-mural care- and social facilities (such as protected homes, half-way houses and communal appartments), until self-responsibility can again be assumed. Successful rehabilitation depends further on adequate support within the social area (i.e upon the occupational sector) through the availability of protected work-shops, occupational training facilities, and assistance from governmental agencies for procurement of suitable positions upon the free work market. Rehabilitation is finally furthered by the provision of hobby and free-time programs for patients who have frequently spent years within the protective boundaries of hospital care.

The opening-up of psychiatric wards and hospitals naturally represents a pre-requisite for the success of rehabilitative projects and thereby for bed-reduction in order to end the overcrowding which heretofore prevented a positive development. Here too, the question arises as to how many new admissions are destined to become long-term hospital cases. A reply to this query however, requires statistical back-up over a number of years and is not as yet available. Within the case group of what we identify as "old" long-term hospital inmates ineligible for rehabilitation, a further sub-division according to diagnostic criteria can be effected and differentiating treatment programs applied- partly in home-like surroundings within the hospital, partly (in the instance of extensive brain lesion,- highly re-

retarded,- or alcoholic dementia cases) within hospital care units that permit the exercise of behaviour modification therapy.

CONCLUSIONS

In summarization it can be said that a reformation of the psychiatric hospital can only be effected, if the below listed program can be put into operation:

1. Abolishment of overcrowding (primarily upon the chronic case sector) by removal of chronically ill patients into protected dwelling facilities.

2. As soon as justifiable bed numbers and an adequate staff-patient ratio have established more humane conditions, the effect of late-onset rehabilitative programs will further reduce the number of long-term hospitalizations.

3. Early-onset and follow-up rehabilitation programs (i.e. intensive integrative care, combining pharmacological and psychotherapeutic treatment)and provision of supportive measures after discharge (in the form of socio-therapy) will serve to promote a lower profile upon the long-term in-patient sector with regard to newly admitted cases, although it will not be possible to entirely avoid the revolving-door phenomenon which, incidentally, should not be viewed as a totally negative one.

4. The reform model as such, can only function as an integrative psychiatric program, if phase-adequate and case-adapted optimal combinations of divers therapeutic methods are brought to bear.

5. Implementation of any psychiatric reform program is only possible if complementary extra-mural care units are available and adequately structured. Only through effective collaboration between hospital administration, medical staff, and extra-mural care personnel under coordination of their respective activities, can the continuation of psychiatric care required by the discharged patient, be assured.

How far this objective can be realized in the manner of UNITE DE BESOIN (i.e. an overlapping care system net, encompassing psychiatric hospital, extra-mural care units, and penetrating into the home and occupational sphere of the patient), will be a matter of public health policies and the manner of their implementation.

ORGANIZATIONAL PROBLEMS OF PSYCHIATRIC HOSPITALS

EVOLUTIONARY MANAGEMENT

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The question of new organizational structures has become very topical for various reasons. Among the most important of these are certainly the changes that have taken place in the psychiatric hospitals themselves.

They can be summarized as follows:

1) Transition from custodial to curative and rehabilitating functions of psychiatry.

2) This transition is marked by a multiplicity of therapeutic methods.

3) The many new therapeutic and rehabilitative procedures have led to a reduction in the hospital stay, to the rehabilitation of chronic patients and thus to a decrease in the number of patients and of patient-days spent in the psychiatric hospital. At the same time, these numerous therapeutic activities have necessitated an increase in staff.

4) Special rooms have been equipped as ateliers and workshops for therapy.

5) The expansion of out-patient services has also helped reduce the number of patients needing to be hospitalized.

6) There is no longer such a clear distinction to be made between in-and out-patient sectors, since hospitalized patients are now treated in day-care facilities or attend out-patient clinics from the hospital for certain procedures such as infusion treatment.

The active treatments and the changes in the number and fluctuation of patients have altered the allocation of duties and thus the management structure of psychiatric hospitals as well. Whereas there was previously a single director, with an administrative assistant, now either these are equal in rank and responsibility for management, or there is a management team, consisting of medical superintendent, the head of the nursing service and the administrative director. These changes in the organization of the hospitals and their management have caused increasingly urgent economic and especially managerial problems. Doubt is thrown on the validity of the old hierarchical style, summed up in the three C's: command, control and correction. This is especially the case since industry has also realized that this style of management no longer suffices today, as it cannot keep pace with the required changes. It has been the experience both in hospitals and in companies that intense activity is generated in the higher echelons of management, far-reaching orders, instructions and other papers are produced, and a year later when stock is taken it is seen that practically nothing has changed at ground level, in fact the information has not even penetrated so far.

Attempts are now being made in the framework of cost containment to tackle the problem of management in clinics and hospitals afresh. A management course for hospital managerial staff sponsored by the Swiss National Foundation was conducted under a general project for cost containment within the health service. This first course of its kind was conducted by the Institute for Business Administration of the Graduate School of Economics in St. Gallen. From our hospital, the Medical Superintendent, the Administrative Director and the Personnel Manager participated.

At this course, we were familiarized with the concept of "evolutionary management" developed from systems theory by FREDMUND MALIK and GILBERT PROBST of the Institute for Business Administration of the Graduate School of Economics in St. Gallen, directed by Prof. H.C.H. Ulrich. From the viewpont of cybernetics and systems theory, the classic managerial style from the top down can be seen to be a product of linear thinking. In contrast, modern systems theory in particular demonstrates the need for circular thinking, whereby great stress is laid on the role of feed-back. This feed-back in turn controls central decisions. The latter comprise, however, not only those central decisions which have to be handed down and again checked by feed-back, but also information which is to be distributed horizontally throughout the structural network of the hospital. It is this kind of communication which has a greater importance than had previously been admitted.

This is the starting point for the "evolutionary management model". The concept starts from the premise that the individual is all the more ready to undertake an activity when he or she has the feeling of having participated in the preparatory disucssion and decision-making. So evolutionary management involves not centralized discussion, decision and delegation,

but the analysis of problems at departmental level, followed by discussion and the formulation of new concepts. The latter can then be carried out in a highly motivated manner. The central idea of evolutionary management is that good ideas which are accepted and represent an advance, will spread to neighboring departments. This represents a certain shift of both analysis and discussion from the centre to the periphery. This has the additional advantage that innovation, which has traditionally always originiated in the periphery does not have first to make its complicated way up to the top, be analysed and discussed there, and then back again as a command. In evolutionary management, the members of the managerial team rather consult the individual departments on a regular basis to inform themselves of developments which are occurring and to discuss them at the individual level so that they can be put into practice on a trial basis. This has the further advantage, compared with the centralized system, that planning errors can be corrected much sooner and at a lower level than when such errors occur centrally, affecting the whole hospital. With evolutionary management, it can be assumed that a good idea which can be put into practice and represents a real advance, will spread in an evolutionary manner and finally involve the whole hospital. Of course, decisions of principle still have to remain, the province of the management team, and medical decisions that of the superintendent.

Personally, I accepted these ideas very readily and have been pursuing them, because it has always been my experience that centralized decisions can only be carried out when there is the necessary motivation in the periphery. Experience has shown that there is no better motivation to accept or comply with something new than when one has the feeling of having participated in the decision process oneself.

For the psychiatric hospital, in fact for psychiatric services altogether, this idea will probably be accepted more quickly by doctors than by the administration or the political departments responsible, since evolutionary management means a transfer of decision-taking to the periphery, and this could be misconstinued as a loss of prestige. On the other hand, it is medically quite obvious that each department or structural organization will develop in its own way, i.e. differently from all the others, whereas this can naturally seem problematical for someone who thinks primarily in administrative terms. This is so because a number of similarly organized departments are easier to administer than a number of distinct ones. A further special problem here is that the need for staff may be greater or lesser depending on the departmental structure. This in turn can lead to tension between departments, which clearly does not facilitate central management, particularly for the personnel sector. Life is much easier for the latter when the same number of staff are available in each department for a given number of patients and if possible can be exchanged at any time. This is, however, not the case, for example, in the recent concept of "therapeutic communities", as here the team must grow together and remain stable. The possibility of exchange of personnel is reduced. Growing together also means that there is greater understanding for the concerns of

the department than for those of the hospital as a whole, although the latter are the principal responsibility of the hospital management. It cannot be overlooked, however, that a team is better for the patient's welfare than a group of people who just happen to work in the same department. Moreover, each of these teams often needs looking after and leading in its own specific way.

Yet, it must be said that evolutionary management merely intensifies a trend in communications which already exists in hospitals and other institutions. Circular thinking, even if without the name, was always present, expecially in the sense of circulating information systems, and was traditionally opposed to the predominantly linear thinking of the usual management structures, especially the strict insistence on "doing things the official way".

Evolutionary management also calls for the increased participation of central management at the periphery, however, and this contributes largely to the clearer understanding of what is really going on there than with the classic managerial structures. A further consequence is that it becomes essential to take psychological apsects into consideration within the management framework. Precisely in this respect, the study of business administration has shown that such consideration of the particular characteristics of the individual members can only increase the efficiency of the whole system.

In this sense, I believe that evolutionary management will be of great significance for hospitals, and especially psychiatric hospitals, in future.

References (updated)

Guentert, B., Probst, G.: Informationssysteme unter der Lupe. Schweizer Spital No.2, 1984.

Guentert, B., Probst, G.: Das integrierte Informationssystem. Möglichkeiten und Grenzen. Schweizer Spital No.3, 1984

Heim, E. (Ed.): Milieutherapie, Huber Bern Stuttgart Vienna 1978.

Jones, M.: Prinzipien der therapeutischen Gemeinschaft. Huber Bern Stuttgart Vienna 1976.

Malik, Probst, G.: Evolutionäres Management. Die Unternehmer No.2, 1981.

SECTORIZATION OF A PSYCHIATRIC HOSPITAL - WHAT FOR?

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1. This is a report on the reorganization of a large mental hospital, the Psychiatric Hospital of the City of Vienna - Baumgartner Höhe (which is the only one in Vienna) from 1978 to 1983 and an attempt to evaluate its effects. (Gabriel, 1980. 1983, in press. Gabriel and Purzner, in press) Starting from a criticism of psychiatric care facilities there have been formulated some theses and leading motives of the reform (Zielplan, 1979):

1.1 A community as large as Vienna (about 1,5 Mio of inhabitants is to large and difficult to survey. Thus it is necessary to divide the area into regions easier to survey and more homogenous.

1.2 Even if it is not possible to create in-patient institutions which are localised in the regions it makes sense to assign a particular department of the existent hospital to each region. Thus the hospital has to be developed to a conglomerate of departments with obligatory and comprehensive care tasks for one region each.

1.3 The organisational principle of regionalisation is not contradictory to the principle of the differentiation of services for acute and longterm adult patients, demented people and mentally handicaped, in each case men and women, if the catchment area of the department is large enough so that the necessary capacities of the differentiated services coincide with general organisational structures (wards). Thus the regional departments have to be divided into services with clear-cut functions for each ward.

1.4 On these grounds cooperation between in- and outpatient facilities may work even if they belong to different bodies so that they are pooled only in order to fulfill the care tasks in common.

Thus the in-patient departments and the out-patient institutions have to cooperate very closely.

1.5 In this way it should be possible to reduce administrative prevalence and incidence of psychiatric in-patients, first of all reducing the rate of in-patients at a key day and reducing the time an admitted patient spends in the hospital. It should be possible to reduce admissions but to achieve that purpose will take more time and only will be possible if the chance will not be neutralized by the simple fact that a discharged patient (as a potential in-patient before first admission) has some statistical risk to be hospitalized but a longterm in-patient has not.

2. What have been our experiences?

2.1 In fact the area of the City of Vienna has been divided into 8 regions each of a population of about 150.000 to 250.000 inhabitants.

2.2 Each of the preexistent departments in the mental hospital has been assigned to a particular region and has to fulfill obligatory and comprehensive care tasks for adult and senile psychiatric in-patients as for mentally handicaped. The last step of this reorganization was to decentralize the admissions from an admission center in the wards for acute patients of the departments (spring 1983).

2.3 The different wards (5 - 9 with a mean capacity of 40 beds) of a department (with a total capacity from about 200 to about 350 dependant mainly on the regions population) got different duties in acute psychiatry, long term psychiatry, gerontopsychiatry and the care for mentally handicaped adult people. This should lead to
- a better compliance with individual needs of the patients (Gabriel, 1983)
- qualification processes and by this mean to a better compliance with therapy/rehabilitation needs of the patients and
- better preconditions for the intra-/extramural cooperation.

2.4 The intra-/extramural confines represent a sensible area prone to conflicts needs for delineation, frustrations of selfesteem and all kinds of incompetence and unwillingness basing arguments. Probably only one body for intra- and extramural regional services and only direction of both the regional services would contribute to an easier solution of these problems. But the organisational principle 'regionalization' was cut out by the principle of different bodies which is based on historical and administrative grounds.

2.5 It is a matter of fact that these organisational interventions markedly improved the conditions psychiatric in-patients have to live in, psychiatric professionals have to work in and

both patients and professionals have to cooperate in. Even independant on their special content they stimulated changes. (Gabriel, 1980) But is also a matter of fact that this is not enough. It is difficult to evaluate the effects of the attempts to innovate psychiatric care. To often the evaluation is subjected to interests and not unemotional enough.

2.5.1 Unequivocally the rate of hospitalized people has decreased. From 1978 to 1983 it was reduced in the hospital under consideration by 36% due to discharge and not due to transfer, admissions allways reaching approximately the same level. Differences between the different departments occur (- 9% to - 45%). It is not possible to interprete these differences from a single aspect. The aspect of the departments history seems to be the most valid. I assume that the organisational interventions and the general atmosphere of reform both have stimulated the evolution but I am not sure whether it has to do with regionalization.

2.5.2 What concerns the evolution of regional admission rates we only dispose of data since 1980. So we can compare the evolution from 1980 to 1982. In this space of time admissions decreased by 3%. This corresponds to the decrease of the Viennese population. But again the evolution differs highly from one region to the others. In two regions the decrease is very important (- 15%, - 23%). In both cases this can not be explained by changes in the regional population. Again the facts can not be explained from one single aspect, particularely because the care system has not developed to the same level in both regions. In one case it can be described by 'well developed in-patient department in good cooperation with an extramural institution which does not dispose of all facilities as yet', in the other case by 'missing in-patient department and well developed extramural institution which is very active just in the forefield of hospital care'. Apparently important decreases of in-patient rates do not occur in the same departments where admission rates go down markedly. May be this facts can be explained by the different historical situation of the departments. Those which try to reduce the rate of in-patients at the same time are not able to counteract the risk of readmissions as well. To reduce the in-patient rate seems to depend mainly on the activity of the in-patient department but the decrease of admissions seems to depend mainly on the quality of cooperation between the intra- and extramural services.

2.5.3 The general atmosphere of reform has been mentioned as a factor influential on the described development - may be more influential than sectorization itself. Is it possible to evaluate this atmosphere? We tried to use 3 parameters, e.g. the quality of the therapeutic/rehabilitative programmes in the acute wards of the departments, the activity of the out-patient services and the quality of the cooperation of both institutions, all related to catchment areas. It deals with global evaluations performed by 5 inde-

pendant observers (directing medical and nursing staff of the hospital) who know the field in a comparable manner. In fact the evaluations have been very homogenous. I like to point out that the observers evaluated both the quality of the programmes in the acute wards and the activity of the out-patient services better than the quality of cooperation. This result stresses the particular sensibility of the area. As was expected we did not find simple systematic correlations between the changes in administrative prevalence and incidince and the evaluations of the 3 parameters. But they illustrate the status quo of psychiatric care in the different regions.

3. Coming back to the starting point of these reflections I shall try a summarizing answer. The institutional advantages are clear:
- the catchment areas are easy to survey
- the differentiation of the in-patient services remains possible and may be finds even better solutions because of the lower number of patients one specialised ward
- the change of a good intra-/extramural cooperation increases and its risks become more transparent
- so it should be possible to counteract these risks.

Thus sectorization within the hospital creates better preconditions to achieve the essential goals, e.g. a better compliance with the patients needs. 'Sectorization' seems to be not only an organisational tool but also a suitable parole in a mainly organisational phase of reform which creates useful preconditions for another phase - a phase of increasing and differentiating therapeutic tools and goals which should be the essence of the reform.

References

Gabriel, E., 1980, Psychiatrisches Krankenhaus in Bewegung, Psychiat. Clin., 13:242-252.

Gabriel, E., 1983, Patienten im Psychiatrischen Krankenhaus - vom Standpunkt der Psychiatrie, in: "Patienten im Psychiatrischen Krankenhaus", Wiener Kommunale Schriften. ed., Presse- und Informationsdienst der Stadt Wien.

Gabriel, E., in press, Die psychiatrische Versorgung in Wien, Eine Skizze ihrer Reform, in: "Psychiatrie in der Grosstadt", K. Böhme, ed.,

Gabriel, E., and Purzner, K., 1983, Target systems of psychiatric institutions and manpower requirements, Symposium communication "Manpower requirements in Psychiatric Hospitals", VII World Congress of Psychiatry, Vienna.

Zielplan für die psychiatrische und psychosoziale Versorgung in Wien, 1979, Wiener Kommunale Schriften, Band 5B. Presseuns Informationsdienst der Stadt Wien, ed.

STRUCTURAL REFORMS OF A PSYCHIATRIC HOSPITAL IN THE ACUTE PSYCHIATRIC AND LONG-TERM PSYCHIATRIC SECTOR AND THEIR RESULTS

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INTRODUCTION

Structural reforms are dependent on certain developments which,especially in the field of psychiatry,do not only comprise their spheres of concern.There have always been reform movements in psychiatry.But here the socalled ideological reform models tend to ignore facts of reality so that feasible ways may easily be disregarded.

In Upper Austria the changes in psychiatry are tried to be carried out by adapting them to the existing conditions of reality which is of course also true for the changes in the inpatients field of psychiatry.I would also like to mention that the changes concerning wards can only be carried through in a sufficient way,if extramural compementary facilities are established and available and an adequate work in the public is closely connected with it.

Datas

Upper Austria is a province with 1.27oooo inhabitants. The central psychiatric hospital in the provincial capital Linz takes care of a major share of ward psychiatric patients.With all other facilities of medical care the percentage of neurological disturbances is much higher and the percentage of endogene psychoses,first of all schizophrenia is accordingly highas in the Wagner-Jauregg-hospital.

The following numbers show how the situation between 1977 and 1981 has changed.

Table 1.Wagner-Jauregg-Hospital(WJH)
Psychiatry

	1976	1981	Diff.in %
admissions/1oooinh	3,67	4,12	+12,3
beds occup.total	1749	1464	-16,3
beds occup.long-t.	1164	879	-24,5
duration of stay in days	2o,2	14,5	

Tab.1 shows the changes or the extent of utilization and patient capacity respectively in both the fields of acute psychiatry and long-term-psychiatry.

Table 2.WJH ward patints.Change of distribution of diagnosis in %.1976/81

	Acute psych.	Long-term psych.
Old-age dis.	-1o,9	-44,o
Alkohol.	- 4,2	+ 3,6
Sch.	- 2,5	-37,2
MDD	+33,3	-22,7
Paranoia	+85,7	-3o,o
Politoxicomania	+5o,o	-
Psychor.Dist.	+144,o	+338,5
Oligophrenia	-33,o	-25,o
Epilepsy	-58,8	-49,1

The changes in the spectrum of diagnosis are shown in this table. A significant reduction of the rate of schizophrene patients on long-term therapies as well as of the rate of old age diseases is remarkable. In the acute field there is a tendency towards the admission of psychogene disturbances and disturbances of the manic-depressive form. This is indeed due to the increasingly diversified methods of treatment, e.g. psychotherapeutic possibilities. The rate of admissions and continuous hospitalization of oligophrene patients could also be reduced.

Voluntary admissions have reached a high frequency in the observed fields at the WJH. The degree of 86% may be considered as ideal, as the remaining 14% consist of real compulsive hospitalization and incompetent patients.

Table 3.WJH acute psychiatry
dismissals in %

	men		women	
where to:	1976	1981	1976	1981
practitioner or specialist	78,9	77,6	73,4	72,2
home accomodation	4,o	4,7	2,4	2,5
long-term psychiatry	5,5	5,4	17,4 (incl.gerontpsych.)	2o,6
other hospitals	3,6	3,8	3,o	3,o
died	4,1	2,2	1,2	o,3
other	3,9	6,3	2,6	1,4

Tab.3 illustrates the mode of dismissals from the wards of treatment.The high rate of women being admitted to long-term-psychiatry depends on the establishment of a geront-psychiatric female ward which is connected with the long-term therapy.

The mode of admission is illustrated by the example of Linz in Tab.4.

Table 4.WJH kind of admission in %
(from the City of Linz)

	1976	1981
from the practitioner	33,9	38,4
from the specialist	14,4	9,9
from hospitals	18,2	28,o
"parere"	14,5	12,8
other(f.i.direct)	13,1	1o,9

The change also becomes evident by the degree of voluntary admissions. Tab.5

Table 5.WJH acute psychiatry
voluntariness in %

	1976	1981
men	37,4	59,4
women	72,2	86,4

These are only some figures to illustrate the changed structure. In order to make possible it was necessary to effect a whole series of measures. I would like to mention some of them once again: first of all the diversified

spectrum of therapies ,especially in the fields of psychotherapy , and the usage of social therapeutic methods as there are regular daily routine of the patients, the introduction of relaxed discussions and optimisation of the biological psychiatric possibilities.

The long-term field was regionalised , changed in its structure , the principle of chronic wards was abandoned , and special fields of rehabilitation with a correspondingly enforced spectrum of therapies were created.For old age psychiatry special wards for both sexes were established.

Despite a reduced patient capacity the level of hospital staff could be maintained or enlarged respectively. This applies for all fields of jobs. By means of a training of the staff and a more diversified view of psychiatric problems a general improvement of the conditions could be achieved, which is of great importance for rehabilitation measures. Of course these measures have not yet been concluded.

Finally it may be stated that a vital change in the structure of the WJH has taken place during the last few years.Although admissions have not decreased in the field of treatment as is often reported of in literature,there is a tendency towards a more qualified care especially in the field of abnormal reactions and depressive diseases.The expanded spectrum of psychotherapy may well be the reason for that.

In long-term psychiatry there is a significant reduction of patient capacity first of all of schizophrenic patients. This indicates that one has succeeded in dismissing a considerable share of socalled schizophreniacs and enable them a life in their families or in adequate homes. This is predominantly due to social therapeutic measures together with a drug treatment.

Organic psychosyndromes arise as a new source of problems which first of all result from chronic alcoholism. The possibilities of treatment of this group are still rather poor and I think that a main field of research in this sphere for all three pillars of psychiatric therapy, that is biological drug treatment, social therapeutic measures and psychotherapeutic methods, should be established.

SUMMARY

The changes in psychiatry do not only strongly concern the establishment of extramural complementary facilities and the influence of public opinion, but first of all the structure of psychiatric hospital.

In the Wagner-Jaregg-hospital in Upper Austria acute as well as long-term psychiatry have been changed considerably during the last five years.A more diversified spectrum of therapy, reduced hospitalization and aimed methods of

rehabilitation has lead to a significant reduction of long-term patient capacity. Organic psychosyndromes as a new source of problems are mainly a result of chronic alcoholism. The changed structure may be well noticed by the great number of voluntary admissions, by the shorter hospitalization, by an increased number of patients admitted because of psychogene disturbances and of depressions of all kinds, as well as by a very diversified therapy spectrum.

References

Bergener,M.,1982,Gemeindenahe Psychiatrie-Die Bedeutung ambulanter und mobiler Dienste am psychiatrischen Krankenhaus,in:Psychiatrie der 8oer Jahre,M.Bergener. ed.,Verlag Karl Thiemig,München.

Bericht über die Lage der Psychiatrie in der BRD,1975, Bundestagsdrucksache 7/42oo.

Hofmann,G. und Schöny,W.,1983, Strukturen psychiatrischer Versorgung, in press.

Wing,J.K.,1982,Sozialpsychiatrie,Springer Verlag,Berlin, Heidelberg,New York.

COMMUNITY BASED TREATMENT AND REHABILITATION FACILITIES FOR THE MENTALLY ILL - THEIR EFFICIENCY AND PROPHYLACTIC EFFECTIVENESS

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The last ten years have been particularly noteworthy through our efforts to prevent hospital admission or at leats to reduce the length of in-patient stay by means of the establishment of half-way houses, hostels and sheltered employment facilities for the mentally ill.

Our efforts have had the following results. Through the establishment of Psychiatric Units in District General Hospitals the over-extended catchment areas of the Psychiatric Hospitals has been reduced.

Half-way houses and long stay accommodation with a more homely and less institutional character than the normal psychiatric hospital ward have been established as well as a range of Rehabilitation centres and sheltered employment facilities with different therapeutic aims and methods.

A number of self help groups, voluntary associations and Patients clubs have also some into being.

What effects have these attempts to broaden and deepen our extrahospital treatment and care facilities had upon the Psychiatric Hospitals themselves?

In order to answer this question we want to take the Psychiatric Hospital Weinsberg as an example.

Ten years ago the hospital had 1.000 beds and offered, in comparison to today a very much restricted spec-

trum of treatment and care possiblities.

Since then the beds have been reduced to approximately 500, for us a sure indication that our outpatient and other extra-mural therapeutic facilities are having a tangible effect.

Also the readmission statistics support this hypothesis in that the readmission rate fell from 56 % in 1968 to 45 % in 1979 and has since remained relatively constant.

Further, the length of inpatient admission has been progressively reduced. In 1968 only 30 % of the patients remained in hospital for 30 days or less. The figure rose to 61 % by 1974 and has since stabilised at between 55-60 %.

Likewise the percentage of patients remaining in hospital longer than 1 year is also reduced. In 1968 the figure was 5 % and by 1976 had fallen to 1 % at which it has since remained.

The admission diagnosis statistics allow us also to deduce that a change in the structure of the client group has taken place.

In 1968 the largest admission category were the schizophrenias who amounted to 24 % of the admitted patients. Today this group account for only 16 % admissions. At the same time the percentage of alcohol and drug dependent patients has risen from 17 % in 1968 to 22 % in 1980.

A very large increase in the admission of neurotic and psychosomatic patients has taken place.

In 1968 only 0,5 % of patients were in these categories and by 1982 the percentage had risen to 9 % an indication of an accepted and acceptable choice of treatment facilities that the modern psychiatric hospital has to offer.

These are only a few examples of the changes that have taken place in the last ten years.

What has caused this to come to pass?
Without doubt the establishment of out patient and extra-hospital treatment and care facilities. Further information and more exact statistical indications of treatment effectivity are available to us from the Weinsberger Case

Register. (The data is obtained from routine Documentation and from this documentation the data from 28 separate criteria are obtained and processed). Since its establishment some 40.000 treatment episodes have been processed and the information stored.

Of particular interest here are questions that concern the patients diagnosed as schizophrenic. This group ist certainly a relatively small part of the admitted patient population, they require however special emphasis to be placed upon an effective aftercare. It ist these patients, often unemployed or without a skill or trade. These patients suffer especially from deficiencies in normal social skills and these deficiencies are further complicated in that after the acute phase of the illness is over there remains a reduced level of overall ability.

It ist this group of patients that gravitate toward a chronic condition so quickly when the necessary preventive measures are not undertaken. Even today such chronic patients make up 50 % of the population of many psychiatric hospitals.

Just as damaging and form the long term viewpoint purposeless in the phenomen of admission-early discharge-readmission, the so-called "revolving door psychiatry", when after the end of the acute phase of his illness the patient is discharged without any social or occupational aspects of his illness and lifestyle being considered and planned for.

What can we ascertain?
A primary prevention of mental illness appears to be impossible. Although the number of first admissions is apparently very slightly reduced a noteworthy trend is not apparent. However in respect of the prevention of readmission, the so called secondary prevention there appears to be the following picture.

In the last ten years approximately the half of all first admissions must sooner or later be readmitted. This figure despite small fluctuations has remained relatively constant between 1968 and 1981.

However between 1968 and 1972 the period during which our half-way houses and other community based support facilities were established our readmission rates were reduced by 14 %.

The duration of inpatient stay was also reduced and

this without an increase in the relapse rates.

The average length of stay in 1968 was 259 days and by 1974 the figure was down to 86 days.

In respect of the so called tertiary prevention the statistics show also some degree of success for our efforts. Only 20 % of the patients who we transferred to a rehabilitation centre must be returned to us. However from our calculation a definite rehabilitation i.e. discharge from day clinic/night clinic status in the period between 1968 and 1981 took place in only 10 % of the patients.

From our data it is also possible for us to discover certain problems and also to examine all pertinent facts there to appertaining in some detail. For example whether different rehabilitation units and programs have different effects and the costs that are involved. Considerable differences between the activities of two psychiatric units in general hospitals in our catchment area were discoverd as a result of a statistical analysis.

One general hospital unit had as a result of it's community oriented policy caused a reduction in admissions from their catchment area to our hospital. The figure fell from 7 % to 1 % in 10 years. In another unit in the south of our catchment area the admissions to our hospital were, after the opening of the new unit, doubled. What this actually means is not really to us clear. It can be that this new facility had discovered a new need without being able to fulfil that need.

To the question of cost effectiveness. We have examined a Therapeutic centre in our neighbouring city Heilbronn, this centre the Therapeutikum has a sheltered workshop with 100 places and a hostel with 100 places in community style homes.

This examination has shown to us that the costs involved in such a project are economically good value for money and lead to an overall positive assessment.

By the evaluation of such activities one arrives also at a favourable opinion also when from the perspective of the worker in a large hospital such efforts are, in comparison to the work involved rewarded with a barely measurable success.

This inability to accurately ascertain progress and thereby success can possibly be connected to the fact

that, at the moment, we do not know which patients are most suited to which therapeutic-rehabilitation facilities and when we have this information, when we are able to isolate and identify the various factors concerned then we will be better able to measure success and failure. At the present moment our criteria for the selection of a patient are not based upon psychiatric grounds rather upon the right of the patient to an invalidity pension upon health grounds and this, is in the last analysis the deciding factor as to whether or not the patient is accepted for a rehabilitation program.

On the other hand it is now completely accepted that there exist patients who, in the absence of rehabilitation facilities must remain in hospital and who in this relatively restricted and restrictive milieu must fall prey to the effects of hospitalisation and all that involves.

We have therefore no other choice than to continue along the road that we have chosen, perhaps, in the future, in the realisation that progress will only with great effort, be attained.

Whatever the case, future assessments must have as their goal the attainment of a patient orientated, individual rehabilitation program.

Simple euphoria over a great Reform in the problem of the rehabilitation of the long-term mentally disordered is not enough.

Translated by: Charles Philipp Hancock

PSYCHIATRIC REFORM IN GUGGING SEEN FROM THE VIEWPOINT OF PATIENTS AND STAFF

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INTRODUCTION

The reduction in size and re-structuralisation of large psychiatric hospitals developed more dramatically in other countries, where in the Sixties a hospitalisation rate of more than 4 beds per 1000 inhabitants had been reached, than in Austria. It is common knowledge that the number of occupied beds was reduced as a result of a modified discharge and admissions system, through financial and legislative measures introduced by health politicians, the increased use of psychopharmaca and probably also through the further development of community psychiatric services.

Nevertheless, this method was not always successful in reaching all of the discharged patients, very often in need of help, through the appropriate alternative services, as Greenblatt and Glazier (1975) demonstrated in the USA. The duration of time spent outside the hospital is apparently merely one criterion towards assessing the quality of a particular course of treatment. Opinions still vary greatly as to the optimal organisational structure for psychiatric treatment. It seems therefore appropriate to also ask the patients ie. the users of the therapeutic facilities, how they regard certain reforms.

For this reason, patients and staff were asked for their opinions with regard to these reforms, during a relatively fast executed re-structuralisation of the Psychiatric Clinic for Psychiatry and Neurology in Klosterneuburg-(Gugging).

The most important reforms in the hospital, which has compulsory admission for a catchment-area of 800 000 inhabitants, were a consistent programme of inner sectorisation of all open areas, as well as the

introduction of a compulsory course of treatment for diagnostic and mixed sex groups. The bedrooms, containing a maximum of 3-6 beds, the rest- and function-rooms, as well as the personnel responsible for treatment, were organised into 9 sectors, which correspond to the main-area teams (Bezirkshauptmannschaften) within the eastern part of Lower Austria.

Each of these sector groups receives extensive treatment from the same specialist, who has sole responsibility for this and who also gives advice to and tends to the out-patients two afternoons per week at the appropriate advisory centres.

An average of 12.5 patients from each sector receives in-patient treatment at the hospital, of which approximately 9 participate in a treatment- programme. The rest remain in a comparatively small, closed area- (2 wards each having 24 beds; out of a total of 134 beds). By the second week of treatment already half of the patients are receiving out-patient treatment. (Md= 13 days).

Before this re-structuralisation, the psychiatric clinic in Gugging presented the picture of a more traditional sanatorium, having large sleeping quarters in which acute and long-stay patients (separated solely according to sex), were held in custody rather than treated. Inner sectorisation was accompanied hand in hand with a rapid change from a custodial to an activating psychotherapeutically motivated style of treatment.

However the success of all these attempts at reform is undoubtedly very much dependent on the co-operation of the patients concerned. It seemed therefore appropriate to record the opinions of the patients, nurses and doctors at exactly that point in time when the change in treatment concept took place. This was achieved by means of an attitude questionnaire.

METHODOLOGY

For the investigation an attitude questionnaire containing 35 items was compiled. Some items were derived from Stumme's Cologne Project (1975); others from the Feldes Scale (1978). In addition questions were raised regarding the professional image of the nurses, the teamwork, the sectorisation of treatment and the grouping together of diagnostically diverse patients into collective groups. Using this survey method, a sample of 45 nurses (trained to Diploma standard - 1/2 of which were female, the other half, male nurses), 22 doctors and 48 patients were interviewed.

The data available on this group and the replies of the 48 patients were compared. (40% Schizophrenic, 13% Depressive. 17% Alcoholic,

10% severely neurotically disturbed and 20% Oligophrenic and demented patients).

RESULTS AND DISCUSSION

In the following text, only those results which reveal interesting differences between the groups interviewed, have been selected.

It should firstly be mentioned with regard to the question of the improvement in care provided resulting from inner sectorisation, that all groups reported experiencing a marked or very great improvement. The principle of " Unité des soins", according to which patients who came from a particular region receive hospital treatment from the same therapist; latterly also in the peripheral advisory centres, was also seen generally as an improvement in the relationship.

Significant differences emerged concerning the assessment of the professional image of the psychiatric nursing staff.

Inner sectorisation of a hospital department has the effect that patients from totally diverse diagnostic groups, e.g. alcoholics, Schizophrenics or depressives, are grouped together for purposes of treatment.

This was viewed less favourably by the patients and nursing staff: nevertheless this trend could not be statistically proven.

Table 1. Assessment of the professional image of the psychiatric nursing staff - by employees (n= 67) and patients (n= 48).

Most important task	Patient	Staff	Total
To watch over, maintain order	27	3	30
Conversations Psychotherapy Rehabilitation	21	64	85

$\chi^2 = 19{,}03,\ p < .001$

Table 2. Assessment of collective treatment of patients sharing the same diagnosis - by patients (n= 48), nursing staff (n= 45) and doctors (n= 22)

	Patients	Nursing Staff	Doctors	
For diagnostic homogenaiety	33	29	10	
For diagnostic heterogenaiety	15	16	12	n.s.

With regard to the question of whether emphasis should be placed on single psychotherapy or group therapy, the nursing staff and doctors tended to prefer group therapy, while no apparent preference could be established in the patients case.

The question, whether the treatment of patients should remain solely ascribed to the doctors, or whether treatment should be carried out by various occupational groups such as psychologists, social-workers and occupational therapists, was answered as follows: -The doctors were, without exception, in favour of working in conjunction with various occupational groups. The psychiatric nursing staff, on the other hand, were undecided on this issue (57% in favoor of treatment exclusively from doctors).

The question of mixed wards seemed to us an important one. This innovation was welcomed by 80% of patients and doctors. However almost half of the nursing staff (47%) were against having male and female accomodation within one ward. This can be explained by the fact that the nursing staff are more deeply rooted in the institutional tradition, are also more strongly acquainted with the custodial tasks, and are afraid of the work difficulties they may encounter as a result of this mixing of the sexes.

The results of the Feldes distance scale (1978) which we had built into the questionnaire proved surprising. The replies to almost all of the questions showed that the patients themselves displayed. the most intolerant and distanced attitudes towards their fellow-patients. In the following table is given as an example, the results from item 3 of the Feldes scale -" I wouldn't let patients run around freely".

Table 3. Attitude towards the confinement of psychiatric patients - by patients (n= 48), nursing staff (n= 45) and doctors (n= 22).

	Patients	Nursing Staff	Doctors
For confinement	22%	10%	7%
undecided	47%	36%	20%
against confinement	31%	54%	73%
Total	100%	100%	100%

It can clearly be seen that the patients are most in favour of the incarceration of psychiatric patients. The patients opinion tallies with the opinion of the average member of the public, as recorded by Feldes (1978). Similarly Jaeckel and Wieser (1970) also made comparable findings in a similar study with the townspeople of Bremen. Apparently ones attitude towards the mentally ill remains essentially unchanged by the fact that one has himself been admitted as a patient in a psychiatric hospital.

Patients also felt they would rather assign only undifferentiated work to other patients, would not accept the opinions of the other patients and were not so keen to share the same place of work with them.

However what is striking, is that 47% of the patients are prepared to spend their leisure time with other patients. A mere 26% of the nursing staff and 0% of the doctors were prepared to be with patients during their leisure time as well. This is an important indication that patients-clubs do represent an important opportunity for improving the quality of the care provided. Incidentally 53% of the patients advocate that psychiatric patients should be prevented from having children. 35% are undecided on this issue. 93% of the doctors were against this; or rather undecided.

The patients had positive feelings with regard to an evaluation of the success of the treatment in the hospital. 91% were convinced of the treatment's success. 81% associated the concept of a cure with a psychiatric hospital. Admittedly these valuations vary slightly from the pronouncements of the nurses (77%) and doctors (87%).

The following illustration show clearly once again the relatively restrictive attitude of the patients themselves.

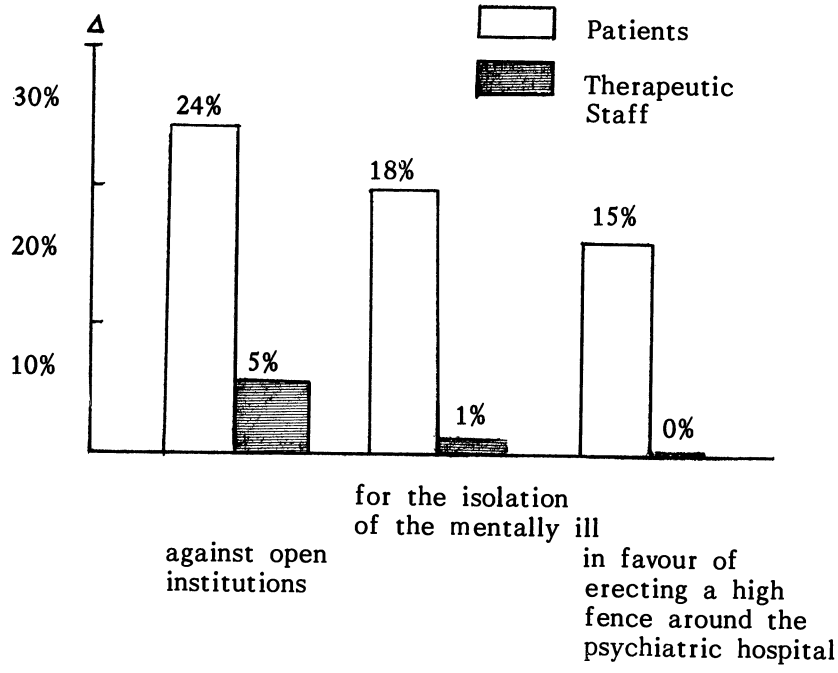

Fig.1. Rejecting attitude of patients (n=48) towards an opening up of the psychiatric hospital in comparison to the therapeutic staff n= 67).

A quarter of the patients expressed themselves against open institutions; 15% were even in favour of enclosing the psychiatric hospital with a high fence. 18% were in favour of isolation of the mentally ill. These results are probably related to the widespread fear amongst the population of the dangerousness of the mentally ill. Evidently having been a patient oneself does not suffice to break down this prejudice.

Admittedly 76% of the patients were agreed as to the question of whether the psychiatric hospital should be complemented by open outpatient treatment. However this point was almost totally affirmed by the nursing staff and doctors and is related, amongst other factors, to the generally prevailing climate of reform-ideology in Gugging. Finally it should once again be emphasised, that the patients who come from a small town or country environment display a very restrictive attitude towards their fellow-patients and regard the reforms, such as group treatment, the accomodation of men and women in the same ward and the opening-up of the institution with some reserve.

References

1. Danzinger, R., Lyon, G., Stix, P. und Tholen, E.: Zur Einstellungsänderung bei Laienhelfern. Psyther. med. Psychol. 32 (1982) 152 - 156
2. Greenblatt, M. and Glazier, E.: The phasing out of mental hospitals in the United States. Amer. J. Psychiat. 132. 1135 - 114o (1975)
3. Jäckel, M. und Wieser, St.: Das Bild des Geisteskranken in der Öffentlichkeit. Stuttgart/New York 197o
4. Laburda, E., Pelĭkan, J.M. und Strotzka, M.: Bericht über die psychiatrische Versorgung in Österreich. Forschungsproj. Medizinsoziologie (Zl.II - 726.028/39 - 16/81).
5. Stumme, W.: Psychische Erkrankung im Urteil der Bevölkerung. München 1975

HOSPITAL REFORM AND PATIENT CAREERS

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More or less by way of illustration I should like to present a very limited aspect of the reform process taking place in our hospital in Liestal, Switzerland, namely the transformation of patient careers inside the hospital.

First, however, I should like to give an outline of the general situation: the hospital ist responsible for the integral psychiatric care of a canton of 220'000 inhabitants comprising partly urban and partly rural areas. The reform began in 1979, the hospital initially having custodial character and a correspondingly hierarchical structure. The reform meant the adoption of sociopsychiatric principles including the establishment of a care network outside the hospital and a simultaneous internal structural reform (which is still far from completion)[6]: opening of the hospital, a relatively autonomous organisation of the units according to the principles of milieu therapy, and the gearing of the long-stay sector to rehabilitation. This has enabled the number of beds to be reduced from 400 to 300, solely at the expense of the long-stay sector.

Patient careers within the hospital have always received our special attention. We regard them as an important structural characteristic which must not be neglected in our efforts to achieve reform. By "career" I mean the illness course structure resulting from the interplay of individual conditions and the situation existing in the institution. In typical careers the patients pass through specific roles, and corresponding characteristics are imprinted on them. Goffman[4] speaks of the "study of the self under institutional conditions". However, according to my observations the classification of a patient as chronic is a decisive factor. I believe that this classification results not so much from "objective" diagnostic

criteria which are independent of the institution as from the unit in which the patient is hospitalised. A patient who lives in a chronic unit is regarded, per se, as chronic[3]. The descent into chronicity and the problem of hospitalism is therefore essentially a problem of differentiation between the hospital units and the scheme of transfers to which the patients are subjected.

In our hospital the following system applied prior to the reform: On admission the patient was placed in the closed admission unit (with restless patients), first in the observation ward und then in a tract with separate rooms. If the patient progressed satisfactorily (i.e. if he succeeded in adapting within a reasonable time) he was transferred to an open discharge unit where he was able to continue his recovery until he was discharged. If his progress was less favourable he was placed in a chronic unit in an older, neighbouring building with resonably pleasant and liberal conditions. If the patient also failed to adapt to conditions there, he was transferred to a unit in an old building further away. This was a collecting place for chronic psychotics, oligophrenics and patients suffering from personality disorders with a severe socialisation deficit.

Thus the patients' careers were characterised by the existence of an "end-of-the-line-unit"[5,7] such as are or were formerly found in many places. This hat the following characteristics: admissions to the unit took place only through a "descending" career, and patients left it only as a result of transfer due to physical illness or on administrative grounds or when they died, and not as a result of rehabilitation. These units were in the oldest buildings of the hospital with the poorest amenities. They were overcrowded, and offered very little opportunitiy for privacy. All the characteristics of a total institution were found there[4], and almost all the unit's long-term inmates showed marked hospitalism[8]. This sector was also a collecting place for "chronicised" nursing personnel, or in other words for staff who hat sought a quiet job far from the main centres of activity.

Thus a hierarchically organised institution produced a difference in status between the individual units. In this structure the career of discrimination which had led to the patients' hospitalisation was continued inside the hospital.

At the beginning of the reform phase we already decided to improve the structure of these units and gradually to discontinue them. This measure had repercussions for the whole hospital: we prohibited transfers and all new admissions to these units in order to "dry them out". This measure was immediately felt in the other units, since it made it much more difficult to relieve pressures within them by transferring difficult patients. Thus the admission units

had to learn more how to handle longer-term problems. Roughly at the same time we introduced a system of personal relationship into the care of the patients. The personal bond that developed between the nurse and patient to oppose such moves. As a consequence there was also a fall in the number of transfers to the open "discharge units" since the teams in the admission units wished to continue treating their patients until they were discharged. Soon these discharge units unexpectedly proved superfluous. An important aid in this connection was the parallel creation of a system of opportunities for outpatient care.

Thus the patient's hospital career was no longer characterised by a routine of transfers. In normal cases the patient remaines in the admission unit, and in time a new problem developed in as much as a few patients "stuck" in the admission units for long periods. This created capacity problems and also resulted in pressures originating from the personnel, who were poorly able to cope with patients who followed such a course. However, these long-stay patients in the acute units differed appreciably from the former chronic patients in the chronic units; they were appreciably more "lively" and sometimes so lively as to cause a disturbance. Whereas the "classical" picture of the chronic patient is one characterised by autism, the scene was now dominated by acute regression forms with psychotic manifestations or excitement conditions (change from understimulation to overstimulation, see Ciompi[2]). We endeavoured to counter this problem by introducing a few special rules and therapeutic frameworks for long-stay patients living in the admission units.

A few patients were able to move back from the chronic units to the acute sector. Activating measures were taken in the chronic units. In some cases this led to a clarification of the symptoms. Such critical moments were then taken as an opportunity to transfer the patient, although this occured relatively seldom.

For appreciable more patients the moving of whole units or relatively large groups of patients also created a new situation with regard to their careers: as a result of the falling number of beds and the planned emptying of certain parts of the hospital, in the last few years almost all long-stay patients have experienced such a change at some time.

These moves have resulted in the patients being placed in more habitable quarters, and above all the opportunity has been taken to abolish the former sex segregation and to create mixed units.

The structural measures I have mentioned so far were carried out with priority. Not until the next phase did we begin with the establishment of an actual rehabilitation unit, which has now been in operation für 9 months. In other words our fist step was to largely eliminate the structures that produced a descending patient

career. Only then did we create the rehabilitation unit as a facility aimed at permitting and ascending career. One of the results of this policy was that most of the hospital was included in the reform from the outset.

What career is now followed by patients admitted to the hospital? - The newly admitted patient is placed in the admission unit. Within the hospital, as a rule his status will not deteriorate further. The overwhelming majority of patients remain in the unit until they are discharged, even if their stay is a long one. Transfer to the rehabilitation unit can be considered for a few of these longer-term patients in cases where it is necessary to build up their "social person" from the beginning. After the patients' discharge there are various possibilities of semi-outpatient or outpatient further care. With regard to the question of chronicity we can say the following: therapeutic resignation in connection with prolonged illness is no longer accepted: patients are no longer pushed aside into the thinly staffed long-stay units. This does not eliminate the problem of chronicity and institutionalism[1,9], but it is always possible to prevent patients from sinking to a vita minima level characterised by severe institutionalism. In most cases stabilisation outside the hospital milieu is achieved. All the patients who now remain in the hospital as chronic cases have severe premorbid handicaps[9] or socialisation defects, and most of them have had long institutional careers in other places.

The chronic patients from previous years have experienced changes of milieu within the hospital, mostly within groups or parts of groups who previously lived together. Their living conditions have greatly improved as a result. We endeavour to ensure a good homelike atmosphere, particularly for patients whose age gives them little chance of rehabilitation. It can be said that in their careers their status hat improved from that of "inmates" to that of "pensioners". At a result of their transfer to the more stimulating acute milieu it has been possible to assign a minority of the long-stay patients to the rehabilitation unit.

The reform has not been without its costs. The patients and personnel have been presented with many new situations with resultant tensions, anxiety and uncertainty. Two suicides of patients can partly be attributed to the relevant changes. A new difficulty has also appeared: in the few cases where it is necessary to transfer patients for reasons of capacity, a process which was formerly a routine part of their careers is regarded as a major crisis by both patients and personnel and costs a great deal of trouble and energy.

On balance, however, I consider the results to be favourable. The effectiveness of an internal hospital reform is no doubt also reflected in its success in giving a new turn to the patients'

careers and eliminating the downward pathway to the limbo of the chronic units. If this has been achieved, the hospital as a whole ceases to be the "end of the line".

REFERENCES

1. L. Ciompi, Ist die chronische Schizophrenie ein Artefakt? Fortschr. Neurol. Psychiatr. 48:237-248 (1980).
2. L. Ciompi, Wie können wir die Schizophrenen besser behandeln? Nervenarzt 52:506-515 (1981).
3. L. Ciompi, C. Agué, P. Dauwalder, Ein Forschungsprogramm zur Rehabilitation psychisch Kranker II, Nervenarzt 49:332-338 (1878).
4. E. Goffman, Asyle, Suhrkamp, Frankfurt (1972).
5. K.Hartung, Die neuen Kleider der Psychiatrie, Rotbuch-Verlag, Berlin (1980).
6. G. Jervis, Kritisches Handbuch der Psychiatrie, Syndikat, Frankfurt (1978).
7. L. Jervis-Comba, "C"Frauen: die letzte geschlossene Abteilung, in F. Basaglia, "Die genierte Institution", Suhrkamp, Frankfurt (1973).
8. H. Kayser, H. Krüger, W. Mävers, P. Petersen, M. Rohde, H. K. Rose, A. Veltin, V. Zumpe, Gruppenarbeit in der Psychiatrie, Georg Thieme, Stuttgart (1973).
9. J. K. Wing, J. Brown, Institutionalism and schizophrenia, Cambridge Univ.Press, London (1970).

THE SPATREHABILITATION OF THE PSYCHIATRIC HOSPITAL

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SUMMARY

More than 20 years ago in Salzburg, the psychiatric reforms started with the opening of the greater part of the wards of the once so called "Psychiatric Care and Nursing home". The "Psychiatric Hospital Department" was opened at the first step. Presently 100 out of 152 beds, which is about 73%, belong to the open part.
Gastager established therapeutic communities and introduced step by step institutions managing the long stay patients, such as halfway-houses and living communities, as well as day- and nightclinics, therapeutic clubs and sectorised long time care after dismissal, which is now been taken over by the social medical unit of the district government.
Since january 1981 we could start with desicive reforms also in the second psychiatric department of the Neural and Psychiatric Hospital in Salzburg, the "Care and Rehabilitations Unit".
For instance the number of beds was lowered from 225 to 187. Of the originally totaly closed department are now 72 beds (38%) in the open and 26 beds in the so called halfopen part.
The present account deals with two themes:

The first part describes the psychiatric care in the district of Salzburg after 20 years of psychiatric reforms and thus gives a survey over the greater frame within the "Spätrehabilitation" is practiced.
The second part discusses the practical experiences and results of the "Spätrehabilitation" in the "Care and Rehabilitation Unit" since january 1981.

THE PSYCHIATRIC CARE IN THE DISTRICT OF SALZBURG

Salzburg is a federal district with about 45o.ooo inhabitants, the district capital Salzburg has about 14o.ooo inhabitants. The district Neural and Psychiatric Hospital as a psychiatric central hospital comprises psychiatric wards for acute and subacute patients, a psychiatric care and rehabilitation unit, further an neural-psychogeriatric department, a neurological department, a neurosurgical department and a neuroradiological department.

The psychiatric department headed by Gastager carries with about 3.ooo admissions a year the greater part of the psychiatric acute care. The average time of hospitalisation of the patients is about 15 days.
This department consists of 2 locked admission wards with 2o respectivly 22 beds, furthermore open wards such as the behavioural therapy unit and the psychiatric ward for younger people and associated are also 2 hostels, a dayclinic and a ward for crisis management.
The Psychiatric Care and Rehabilitation unit comprises two locked facilities for men with 29 respectivly 38 beds, the latter of which was subdivided, one part of which is soon going to be opened. A womens' ward with 38 beds has already been subdivided into an open and a locked part. A Rehabilitation ward with 57 beds belongs also to this department and is organized as a hostel in which the long stay rehabilitation patients are going to be prepared to live privatly outside the psychiatric hospital. This building is subdivided into 12 living communities, each unit offering 2 bedrooms, a kitchen, a bathroom and a WC of its own.
Another main directive of this department lies in the fields of work- and professional rehabilitation. The step by step rehabilitation into the professional life is done through trainings- and therapy programms as well as so called protected jobs in the workshops of the hospital (for instance gardening, laundry, kitchen, administration, tayloring etc.). Presently 23 of these protected jobs out of 3o available ones whithin the ground of the hospital are held by expatients.

Management after dismissal

The psychiatric management after dismissal is performed by clinical institutions such as day- and nightclinic; the care taken by the therapists of the hospital, by private physicians, by private institutions and by the social medical care of the government (Sozialmedizinischer Dienst der Landesregierung). Especially the latter ist carrying the main burden of the following care management. If it is whished each patient after dismissal visited by psychiatrists, psychologists, social workers and (male) nurses at least once an month in his home or is counseled on an outpatient basis.

Further institutiones

The district federation for psychohygiene has two hostels for alcoholics, as well as a counseling institution for drug department people. The association of parents of drug dependent youngsters supports a living community for drug dependent youth and supports them, when they are looking for jobs etc.
The association "Lebenshilfe" with hostels, kindergarden, workshops and day care homes for psychic and intellectually handicapped.
The society PMI (pro mente infirmis) has a halfway-house as well as a counseling board and organizes courses for lay persons, who want to help outpatients. Several social centers and counseling boards are organized as private associations.
Also all the other social servises like "meals on wheels", "home nursing", "Erwachsenenhilfe" etc. has been shown of great importance for the success of the "Spätrehabilitation", because in this way the number of readmissions into a psychiatric hospital out of purely social reasons can be kept low.

"THE SPÄTREHABILITATION"

When Rainer took over the care and rehabilitation department in january 1981 he aspired two main things:

I. the "Spätrehabilitation" in the sense of Gastager
II. the enlargement of the institutions for job and professional rehabilitation

In the end of 198o the department consisted of 4 locked facilities with a total of 225 beds. In prospect was the opening of a rehabilitation ward with the character of a hostel for january 1982. Thus it was necessary as a first step to prepare patients for the moving in this unlocked facility. 87 patients with an average of 46 years and an average duration of hospitalisation of 12,7 years have been included into this preparational training. In a special project, Mackinger has trained these patients together with 12 therapists in 4 groups and prepared them for moving. This project study was financed out of the "fund for the furtherance of science and research". The preparatory training was guided according to several therapeutic concepts, the results of which are compared afterwards. In several publications Mackinger looked at the course of this project.
In january 1982 the patients moved into the unlocked rehabilitation ward and despite many fears out of different directions no difficulties arose. The patients soon found their ways in the new surrounding with ease.
In 1982 Rainer duscussed the possibilities and problems of such a proseeding.
In the course of this move two locked facilities were shut down and the number of beds was reduced from 225 to 187.
As it could be expected, in some cases, people to be put back to

the locked ward for a time. The reasons for that were aggressive behaivor of oligophrenic patients toward other people, psychotic exacerbations where people endangered themselves as well as severe relapses of alcoholism of chronic alcoholics.

On that, some data

Out of 56 patients, who moved in january 1982 to the rehabilitation ward, we could until now (june 1983) dismiss 12 into the private home, 4 others into living communities, 1 patient is in an nursing home. Out of the above reasons, we had to transfer back to the locked facilities 2 patients 3 times, 6 patients 2 times and 12 patients once in that time (january 1982 - june 1983).

To regain the capability to hold a job, means for the psychiatric patients a decisive step to a social rehabilitation. By means of a step by step programm which starts with simple working exercises up to worktrainings and to protected jobs, we try to guide back the handicapped person gradually towards a general capability to work. In collaboration with the job market and the utillization of the possibilities offered by the concerning handicapped people, we try to make use of this regained capability for working in professional life.

In 1981, for example, 41 persons were taken into especial work training. Of these 41 trained people 2o failed, 21 were successful. For 8 expatients we could find jobs on the free job market, 13 are employed partly in the protected workshops, partly in the enterprises of the "Landesnervenklinik Salzburg".

The here described changes from a totaly locked "chronical" department into an department with open wards, hostels respectivly halfway-houses has soon led to a more relaxed relationship toward the public as well as to an improvement of the clime between psychiatry and offices and government institutions. The often encountered principal of saving and safety of some offices has given way to a more positive and dynamic attitude. The problem concerning the chronic psychiatric and intellectual handicapped persons, so far well hidden behind closed doors, has entered the consciousness of the public through his opening.

Doubtless we need further steps on this way and also we shall have to make corrections in some measures taken so far.

Some data show the new dynamics of the department

	1981	1982	1983 (until june)
admissions	122	198	175
readmissions	36	64	49
Hospital (transfer- and retransfer)	8	28	16

average durations of hospitalisation:

1981	2.33o days	=	6,4 years
1982	6o6 days	=	1,66 years
1983	38o days	=	1,o4 years

Especial the here given data clearly shows the success of the measures of the "Spätrehabilitation" also show that the fears expressed of several people, that the number of readmissions of dismissed patients would increase drastially, have not verifyed.

dismissals:	1981	1982	1983 (until june)
private homes	1o4	116	11o
nursing homes	2	12	11
Grafenhof	3	6	11
geriatric homes	7	11	13
hostels for psychiatric expatients	5	3	4
hostels for alcoholics	3	7	1
Lebenshilfe	o	3	2
halfway-houses	1	2	3
living communities	5	2	3

In these 2 1/2 years a total of 14 patients die, however, not through suicide but through medical diseases.

At last a survay over the beds in open and locked wards of the two psychiatric departments.

departments	total	open	halfopen	closed
Psychiatric Hospital department	152 beds	11o beds (ca.73%)	-	42 beds (ca.27%)
care and rehabilitation department	187 beds	72 beds (ca,38%)	26 beds (ca.14%)	89 beds (ca.48%)

As a next step concerning the care and rehabilitation department we are planing to reduce the beds in the locked parts to 51 beds (ca.27%).

PSYCHIATRIC OUT-PATIENT DEPARTMENTS AND THEIR FURTHER DEVELOPMENT - CONTRIBUTION TO STRUCTURAL RESEARCH IN PSYCHIATRY

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More and more, the question of effectiveness and efficiancy of medicine in general, as well as of psychiatry has come into the foreground of public interest.

It is supposed to be common place that a reform of psychiatric care is necessasry and urgent. However, for this decade any actual facilities and treatment plans have not been worked out yet. Even the "Inquiry of the situation in psychiatry in the Federal Republic of Germany", has not changed the present status.

The question arises what really has to be done in this situation?

In my opinion the inquiry has formulated the guide-lines for a "thinkable" psychiatry, whereas now the elements of a "workable" psychiatry must have priority. Its gradual development and realisation has to be based on an extensive conception of medical treatment and care.

Besides the request for medical care within the community, the transfer from in-patient treatment to improved clinic ambulant care, appears to be of particular, may be even pre-eminent importance.

Not only from the theoretical point of view the establishment of out-patient departments was one of the predominant demands put forward in the above mentioned inquiry, in order to eliminate the deplorable state of affaires in psychiatric care commonly being complained about.

Out-patient departments should of course not compete with already existing institutions but cover complementary tasks.

From the very start in the "Rheinische Landesklinik Köln" these demands

were taken into account. This clinic was opened in 1974, with a capacity of 435 patients. The hospital is responsible for the psychiatric care of most districts in Cologne - an area including nearly 900.000 inhabitants. The conception of this hospital is based on the idea of improving the continuity of psychiatric treatment, not only limited to in-patient care. Furthermore the cooperation and co-ordination with other medical and social departments should be promoted, in order to ensure an effective combination of all kinds of medical care.

The advances in psychopharmacologic therapy and the improvement in psychotherapeutics, encouraged the transfer from in-patient treatment either to parttime care in hospital, but even more to the ambulant and complementary branch thus resulting in a decrease of enormous overcapacities in main psychiatric hospitals.

According to the demands mentioned in the inquiry with regard to the effects of out-patient treatment, the following hypotheses can be deducted:

- Reduction of hospital admissions,
- Prevention of wrong admissions,
- Shortening of in-hospital stay,
- Reduction of recidivations,
- Improvement and guarantee of aftercare.

These hypotheses were subjected to an emplric investigation on the basis of statistical data taken from an evaluation regarding the first two years of activities in the "Rheinische Landesklinik Köln" out-patient department. The investigation referred to two different sources of information:

- out-patient department's file,
- records of patients being treated in hospital.

On the basis of these sources the following data were compiled:

- all admissions in the out-patient department;
- in-patient admissions by the doctor being in call;
- all patients being returned as case of emergency in the out-patient department;
- all patients discharged after being treated in hospital.

Furthermore, additional information was included deriving from other hospitals in the Rhineland area as well as statistical material which was handed over by the community health insurance / Cologne (AOK). Those sets of data being important for the examination of the hypotheses were encoded by using a code structure. Each hypothesis was checked twice where possible. As generally known, for retrospective investigations an accurate inspection cannot be obtained. It is well-known, however, that the plausibility of any conclusion is increased substantially, in case it is based on two different sources of information with similar constellation of results.

In the following, let me summarize the results of this investigation. They do of course not allow a kind of final solution. Though the results were not expected of generally foreseen, they seem to be of importance for the future conception and planning of out-patient treatment in psychiatric hospitals.

The assumption that through out-patient care the in-patient treatment could rather be avoided was not confirmed by the trends being analysed in institutions for psychiatric care in the Rhineland area. In fact the continous rise of admissions was not suspended after opening the "Rheinische Landesklinik". The quantity of admissions was increased and even doubled in the area the new hospital was responsible for.

A possible explanation for this development might be that the intensity of use is dependent on type and quality of diagnostic and therapeutic care.

On the other hand the increase of in-hospital admissions is accompanied by a reduction of patient capacities, in the medical care institutions in the Rhineland area - this is indicated by the fact that since 1974 the actual stay in psychiatric hospitals was reduced.

This increase of admissions being observed since the clinic was opened, can first of all be explained by the over-proportionate amount of diagnoses such as neuroses, personality disorders and addiction diseases. Yet in the following years this situation changed evidently. At present, geriatric diseases and drug dependences have come into the forefront.

The second hypothesis - decrease in wrong admissions - shows a trend towards the postulated direction.

The out-patient department's screening function is mainly diminished during the night as well as over the weekend and during times of emergency service. On the other hand there is no doubt that by establishing an ambulant care the primary wrong admissions have been considerably reduced.

The additional hypotheses having been discussed in connection with in-hospital admissions

- reduction of treatment period in hospital
- reduction of recidivations

could not be proved by analysing the chronological data which were taken from different psychiatric hospitals in the Rhineland area. As we have already seen, a higher amount of admissions is accommodated by a substantial reduction in patient capacities. The further development in the "Rheinische Landesklinik Köln", however, does undoubtedly illustrate the positive effect of ambulant psychiatric care within a clinic.

The results of this ivestigation clearly show, that neither the patients' stay

in hospital can be shortened nor is it possible to cut down the amount of recidivations through out-patient treatment. Yet a transfer of patients could be achieved who would in fact require in-hospital care by following the present standards.

Out-patient care after discharge did not influence the frequency of re-admission. In order to analyse this item two groups were compared - one consisting of patients being treated within the clinic whereas the other group included patients without out-patient care after having been discharged. In this respect no difference in the frequency of re-admissions between these groups could be observed. Furthermore no definite results were found with regard to private psychiatrists taking care of patients after having been discharged from hospital. This kind of out-patient treatment did not at all prevent re-admissions or at least significantly diminished the frequency. The admissions amounted to approximately twenty percent independent of whether any after-care was practised or not. Though the analysis of different diagnoses did not result in recognizable differences changes in the distribution of diagnoses, indicate that chief importance in psychiatric therapy is seadily occupied by out-patient treatment; supposedly this development is going to turn even stronger towards this direction in the future. On the other hand a number of serious psychiatric diseased has to be faced which require in-hospital treatment. Although these kinds of diseases steadily decrease, in-hospital care is needed regardless of having the possibility of out-patient treatment and largely independent whether this kind of treatment is being made use of.

Furthermore, the diagnosis is far more important than the kind of medical care and the question if and to what extent the patient makes use of the treatment. The same phenomenon can be observed with regard to the frequency of re-admissions having a distinct relation to the respective groups of diagnosis, whereas the question, how patients are taken care of after discharge only play a minor role.

Surveying the results just being discussed, it is obvious that predominantly they do not correspond with those expectations being developed on the basis of hypotheses and uncritical hopes regarding the efficiancy of out-patient psychiatric care. Yet this investigation did not already disprove the anticipations as a whole. Moreover the investigations carried out so far, show enormous difficulties in the realization of evaluative research in the field of psychiatric care structures.

Having in mind the results of this investigation with regard to the five hypotheses, we can only draw one conclusion - the effects of out-patient treatment have not been clarified yet. Additional tests of ambulant care and the evaluation over a longer period are essential. Until further tests have been carried out, care must be taken regarding any general statements. Still there remains no doubt that out-patient treatment shows positive prospects:

- Realization of multidimensional diagnostic and therapy with multiprofessional cooperation;

- Close connection with different medical disciplines;
- Integral function regarding the integration of psychiatry in general medicine;
- Most of all I see the advantages in the chance to force the growth of specialisation. Psychiatrists, psychotherapists, psychologists, and social workers from a team;
- Another chance is the facilitation of access and finally
- Greater flexibility of medical care personell in acute out-patient treatment in case of emergency.

At any rate, it has to be cleared what on the long run proves to be more efficient in psychiatric care - constancy in medical function, that is to say ambulant or in-hospital treatment whereas the other alternative is constancy in the medical person combinging out-patient and in-patient care.

In order to avoid any misunderstanding, I would like to state that so far no proof has been made to justify attempts to relinquish out-patient care in the future. On the contrary the present investigations impressively show the real importance of such kind of medical care. Within these studies, it is repeatedly required to give up those arguments which declare established medical care structures to be inefficient, though this reasining cannot withstand amiric scrutiny. In addition caution seems to be appropriate towards general conclusions especially because all studies as to the efficiancy of psychiatric out-patient treatment were carried out from the position of in-hospital care and any direct comparison with private psychiatrists is still outstanding.

Regardless the direction, any future activities will be taking: In any case the major command must be absolute guarantee of continuity in treatment and thereby the continuous doctor-patient-relationship. All elements a system of in-community psychiatry consists of should be judged according to this objective and its further promotion and realization.

Let me come to an end. Following general evolutionary principles the necessity of specialisation cannot be neglected. This statement is of course valid for professional practice as well as for the scientific field.

In my opinion, one of the major tasks for the eighties will be the development of a dynamic psychopathology being based predominantly on psychoanalysis, thus supporting practical psychotherapeutic activities. Pharmacotherapy, sociotherapy and psychotherapy are regarded as the three most essential columns psychiatric therapy is rested upon. The theoretical fundamentals derive from biology, sociology, and psychology - very heterogeneous sciences. Their amalgamation in the sense of interdisciplinary cooperation being more than mere multiprofessionality has not been achieved satisfactorily. There still exists a despressing discrepancy between theory and practice, requirement and reality; pragmatism alone will not help to close this gap. Repeatedly severe criticism is aroused not limited to arguments from the antipsychiatric side. Even supporters are right to request reforms. The present situation can only be overcome by more efforts with regard to scientific character and objectivity of analysis.

THERAPY-COMPARISON WITHIN A REHABILITATION FRAMEWORK

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THERAPY-COMPARISON WITHIN A REHABILITATION FRAMEWORK

In Salzburg/Austria, restructuring of wards was undertaken on a large scale in the course of the general reform of psychiatric in-patient treatment. Among other things, part of the closed ward for the chronically ill was to be closed, and the patients were to be transferred to an open home on hospital grounds in order to meet the requirements of late rehabilitation (Gastager, 1969). The patients chosen were to be prepared for their new living arrangements with the aid of psychological training-programs, so that optimal minimization of the risks involved could be achieved, or better, greatest possible success of the training programs would mean maximum subjective well-being on the part of the patients as well as their successful mastering of the new requirements of the home.

Due to financial support by the "Fonds zur Förderung der wissenschaftlichen Forschung" in Vienna, it was possible to conduct a project which necessitated the employment of additional staff-members for therapeutic and scientific purposes.

1. The Project-Design

For a therapy-comparison study, 78 patients were divided into three groups of 20 patients each and a control-group of 18. One group was to be treated with behavior therapy, another one was meant to function according to the principles of the therapeutic community, and a third would be treated by non-professional therapists only. The control-group would receive the traditional

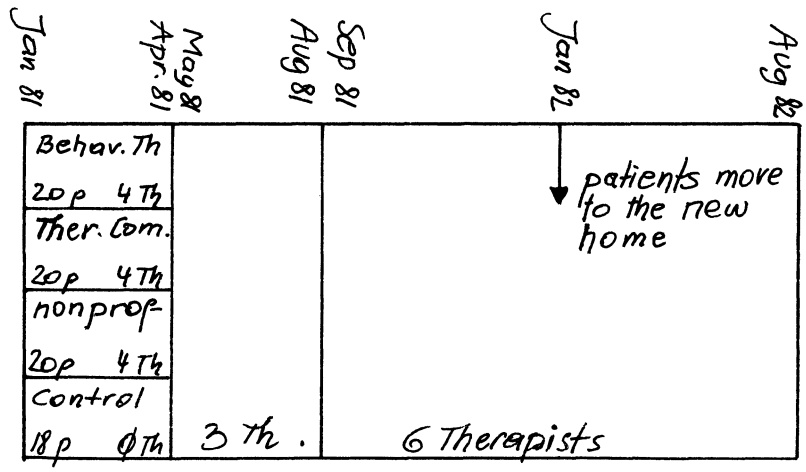

Fig. 1. Project-design, phases

hospital treatment without any additional therapeutic measures taken. There were four trainers at disposal for each of the three active training-conditions, eight psychologists and 4 non-professional trainers. This ratio was prevalent during the first four months, i.e. from January to April, 1981; there were only three trainers at disposal altogether during the following four months, and the sub-division of the groups was terminated. From September, '81, till August, '82, there were six trainers. The transferral of the patients and occupation of the home, which had been completed in the meantime, also took place within this period (January, '82) (see fig.no.1). Training took place each weekday for 2 - 3 hours. Patients were chosen by the ward staff (medical doctors, nurses). 78 from 173 patients were judged to be optimally suited for an open home on clinic grounds. The division into groups was conducted in such a manner, that they should be comparable in terms of diagnoses, age, sex, and length of hospitalization, although without separating friends in the process.

A number of independent variables were assessed: Trainer- and patient-behavior were observed continually, i.e. daily, during the first four months. For trainer observation, we used the "Staff-Resident-Interaction-Chronograph" (SRIC, Licht, 1979), for patient observation the "Behavior-Oberservation-Instrument" (BOI, Alevizos et.al., 1978). Observer agreement was trained on both instruments to a satisfactory degree before onset.

Distributed along the entire 18-month period, 10 patient judgements were conducted on the "Psychiatric Assessment Scale"

(PAS, Krawieka et. al., 1977), and on a slightly modified version of the "Disability Assessment Schedule" (DAS, Jablensky et al., 1980). At three different points, at onset of the project, after four months, and shortly before the end of the project, additional areas were assessed, such as social problem-solving ability (by use of a modified version of the "Means Ends Problem Solving", MEPS, Platt and Spivak, 1975), the personal attribution-styles as well as the intensity and structure of patients' personal values and needs. Further measurements: Therapist Orientation Sheet, (TOS, Paul and Lentz, 1977), sociogrammes, IQ, etc.

As there is not enough room here to present the results in full detail, the possibilities inherent in our research approach will be demonstrated with only a few examples. (for further results see: Mackinger, 1983; Schiepek, 1983). Modelling our's on Gordon Pauls' question: "What treatment, by whom, is most effective for this individual with that specific problem, under which set of circumstances, and how does it come about?" (Paul, 1969), which refers to behavior therapy, though, we could ask here: "Who (what group, organization) contributes what (therapy, money, staff) to which extent (primarily, supplementarily), when (optimal moment in time) and for how long, in order to optimize which effect (economization, patient improvement)? To be more concrete, some of the questions were: Are there differential effects of therapeutic conditions (also in coparison to controls), or among patients with different diagnoses? On which dependent variables do these effects appear? Which effects are merely a result of the occupation of the new home (given consistency of therapeutic measures)? Which are the courses of change? Are there any connections between concrete therapist behavior (independent variable) and patient behavior (dependent variable)?

2. Some Quantitative Results

a) The therapists' behavior: The therapists' behavior was observed daily during the first 75 days of the project in order to assess whether they behaved in accordance with prior expectation i.o.w., in accordance with the chosen therapeutic approach. Furthermore, orientation questionnaires and activity-assessments were used, and from this it was possible to determine with a certain degree of accuracy, that the trainers of the different groups in our project actually did display differing behaviors which corresponded to specifications.

Fig.no. 2 shows the course of one specific behavior (item: "Total of therapists' positive verbalizations to their patients" from SRIC, Licht et al., 1979) over the first 75 days. During the first six weeks, the therapists were told to maintain a "baseline", and only to begin with their specific form of

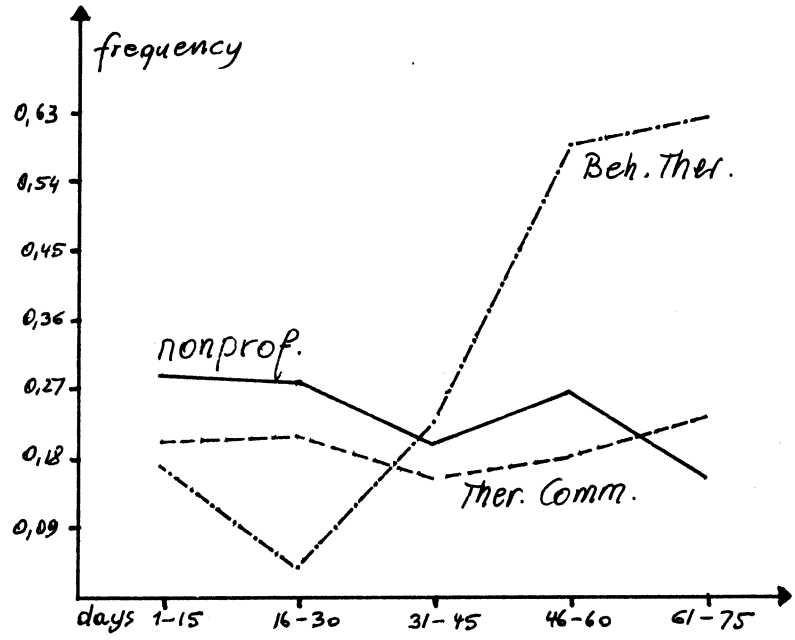

Fig. 2. Trainer-behavior during the first 75 days of the project; category "positive verbalizations to patients" from SRIC (Licht, 1979). The first 30 days were meant as a baseline period.

intervention after that period. Apparently (see fig.no. 2), the specific phase only differs from the non-specific with the behavior therapists (on the concrete item). By correllation with daily observed patient behavior, it is possible to prove direct effects of therapy.

b) Participants versus drop-outs: We see a representation in fig. no.3 (left side, item "depression") showing different effects according to whether the patients participated in the offered training-programmes, or whether they refused participation (drop-outs!). Criterion was the participation in more than 40% of the offered training program-units, or less, respectively. Showing the same values for "depression" at first assessment, from the second assessment on, the two groups differ considerably, "participants" showing the better values. "Participants" "depression"-values drop considerably.

c) Change of living-arrangements: If we supplement the first 4 months of the project by the period between Oct. '81 and Jul. '82 (right side of fig.no.3), during which the occupation also took place, we can clearly see a peculiarity of the course. "Drop-outs" are still much more depressive than "participants", but the "participants", too, show a momentary rise, i.o.w., a relapse to the level of depression at onset in the Feb. '82

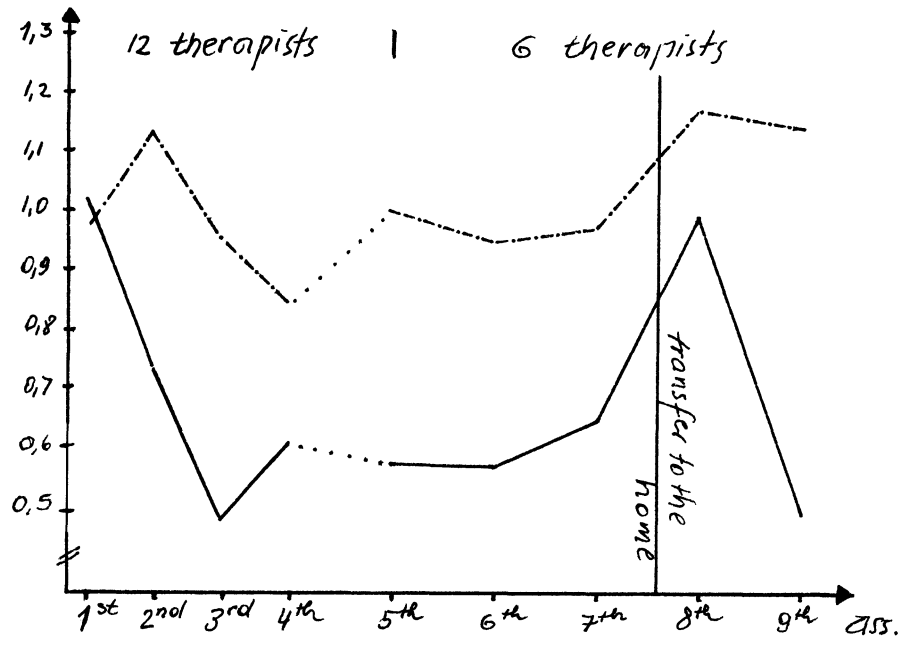

Fig. 3. Item "Depression" from PAS (Krawieka et al., 1977). Broken lines: drop-outs (therapy-resistant), hachure: patients with at least 40% particiaption in training-units. In Jan. '82, the occupation of the new home took place. (expert-ratings)

measurement (8.measurement). This result can hardly be explained in any other way than being considered an effect of moving to the new home. Since - as opposed to drop-outs - the "participants" depression-level soon thereafter drops to the best level achieved prior to moving, one can conclude, that there must be quite a bit of emotional differentiation in the members of this group. It is not obvious, though, whether this is due to patient selection or an actual effect of the training program.

d) Different forms of training: The next question is, whether any specific effects of different forms of training can be found. On the dependent variables mentioned, only relatively small, satistically insignificant differences were reached between training-groups, but significant effects over the time were found.

3. On the Form of Research Chosen

We would like to characterize our approach in the following way: By engaging in "interventive research", an external research staff attempts to change the established structure of an

institution. This staff only spends a limited period of time within the existing field of treatment and attempts tc influence and restructure this field in cooperation with the resident staff, as well as measure and evaluate the achieved effects and the process of change scientifically.

References

Alevizos, P., DeRisi, W., Liberman, R.P., Eckman, T. and Callahan, E., 1978, Journal of appl. Behav.Anal., 11: 243-257.

Gastager, H., 1969, Frührehabilitation und Spätrehabilitation von Psychosen, Psychother. Psychosom., 17: 34-41.

Jablensky, A., Schwarz, R. and Tomow, J., 1980, WHO-Collaborative Study on Impairments and disabilities associated with schizophrenic disorders. Acta psychiat.scand., 62, Supp.285.

Krawiecka, M., Goldberg, D. and Vaughn, M., 1977, A standardized psychiatric assessment scale for rating chronic psychotic patients. Acta psychiat.scand, 55: 299-308.

Licht, M. H., 1979, The Staff-Resident Interaction Chronograph: Observational Assessment of Staff Performance. Journal of Behav. Ass., 1: 185-197.

Mackinger, H., Schiepek, G. und Gurtner, M., 1983, Laien als Therapeuten in einem Projekt mit chronischen psychiatrischen Patienten, in: "Gemeindepsychologische Perspektiven, 2, Interventionsprinzipien", St.Fliegel, B. Röhrle und W.Stark, Hrsg., DGVT und GwG, Tübingen.

Paul, G., 1969, Behavior Modification Research: Design and Tactics, in: "Behavior Therapy; Appraisal and Status", C.F. Franks, ed., McGraw-Hill, London-New York.

Paul, G. and Lentz, R.J., 1977, "Psychosocial Treatment of Chronic Mental Patients; Milieu versus social-learning programs", Harvard Univ.Press, Cambridge, Massachusetts.

Platt, J.J. and Spivack, G., 1975, Manual for the Means-Ends-Problem-Solving procedure (MEPS); A Measure of interpersonal cognitive Problem-solving skill, Hahnemann Community Mental Health Center, Hahnemann Medical College and Hospital, Philadelphia, Pennsylvania.

Schiepek, G., 1983, "Probleme der Praxisforschung in stationären sozial-psychiatrischen Einrichtungen", AVM-Verlag, Salzburg (in press).

IS INSTITUTIONAL TRANSFERENCE AN OVER-USED CONCEPT IN THE TREATMENT OF CHRONIC PSYCHIATRIC PATIENTS?

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SUMMARY

The concept of institutional transference - i.e. relating to an institution rather than to a therapist - was initially observed among a small number of chronic psychiatric patients. Recently, this concept has been over-used to the extent that it has become synonymous with treatment of these patients. This paper describes the observation of the author in an out-patient clinic where the phenomenon of institutional transference is observed among 10% of the general population of the patients who form one-third of those suffering from chronic schizophrenic illness. Therefore, it is far from being a general occurrence among these patients.

BACKGROUND

Relating to an atmosphere, an aura, or fantasy of a physical setting, a clinic, an institution, or a theoretical system was initially described by Reider in 1953 as institutional transference (1). This concept has been useful in relieving the therapist of the difficult task of treating patients suffering from disabling illnesses whose mark will stay with them and who by the nature of their ailment, their distrust and allofness, have difficulty in establishing satisfactory relationships. They may stay dependent upon the system of psychiatric care for the rest of their lives (2,3,4). In recent years, this concept has been generalized to the point of becoming synonymous with treatment of chronic psychiatric patients. It has even been used towards disengagement of one-to-one relationships in chronic psychiatric patients in the hope of increasing the number of patients discharged from an out-patient clinic. (5).

Such a generalization may lighten to some extent the task of the therapist but it pays disservice to the patients who, in spite of difficulty in relating, are able eventually to establish communication, and rapport, and a working alliance with the therapist which may lead them towards therapeutic goals, mainly self sufficiency.

The establishment of a working alliance is a major task with these patients. It requires a long period of time and consistency that a student or psychiatric resident, by the nature of their training and short stay in any given place, cannot provide. This hindrance, along with patients' difficulties related to their illness have been interpreted as the patients' lack of desire for human relatedness and their preferance for inanimate objects. Generalization of this concept has produced another phenomenon - it has depersonalized therapy to the extent that psychiatric staff have had tendencies to relate to the institution themselves, rather than to the patient - in other words, the formation of institutional counter-transference (6). Chronic psychiatric patients, by the nature of their illness, are similar to children, and are extremely sensitive to stability and consistency of the human relationships and of the physical settings around them. The clinical setting can provide a reliable "holding environment" (7,8,9) that they have often lacked and which may enable them towards establishment of an adult relationship and working alliance. Then the clinic gradually tends to become a "home base" reflecting the nature of the relationship linked to it.

In an out-patient clinic, we follow 90 patients of all age groups. These patients suffer from a variety of psychiatric illnesses, (one third from schizophrenia, one third from depression, and the remaining one third, from all the other psychiatric disorders). Half of these patients attend the clinic at least once a month. 75% of the patients are on medications, mainly neuroleptics.

During the first hour, the patients are treated in three groups of six to twelve patients, led by a mental health worker and a psychiatric resident. The groups are open to new members and not all members attend the group on a weekly basis. The group leader's primary task is to establish a rapport and a therapeutic alliance with the newcomer and help him to integrate into the group. This is facilitated by individual interviews during the second hour of the clinic.

About 65% of the patient population of the clinic have a well established working alliance with at least one therapist. They are mostly patients who form the core group within each group (10) i.e. patients characterized by their regular attendance, their tie to each other and to a group leader, and their high tolerance of

irregular or new members. Another 25% are new patients who are in the process of achieving a relationship with a therapist; these are patients who have been in the clinic for less than one year. The majority will establish a therapeutic alliance. The remaining 10% (or 9 patients) who have been attending the clinic, often for years, and who do not appear to have any attachment or working alliance with a therapist, may fit the criteria of institutional transference.

These patients attend the clinic merely to receive their medication from whoever prescribes it and show little desire toward attachment to another person, or even to the clinic as a concept or a physical setting. The profile of these 9 patients is similar to the rest of the patient population of the clinic except that they all suffer from schizophrenic illness, whereas, one third of the general clinic population present that diagnosis. It is noteworthy that the remaining two thirds of the patients with a diagnosis of schizophrenia in the clinic have been able to establish a tie with with a therapist.

DISCUSSION

Over a period of 6 years of observation, working in a clinic treating chronic psychiatric patients, with different diagnoses, we have noticed except for a small number, the patients' capacity to establish a relationship and therapeutic alliance with a therapist. Therapeutic alliance is a rational rapport with the therapist focused on reality and independent of transference (11,12). It takes place between the working ego of the therapist and part of the patient's ego which is conflict-free and capable of observation. It implies also a willingness from both the patient and therapist to work towards certain therapeutic goals. To be able to establish such a rapport the patient requires a capacity for basic trust and identification with the aims of treatment.

When chronic psychiatric patients are treated in groups, the therapeutic alliance may appear in the form of the patient's ability to listen to other group members, an attempt to understand and relate to their experiences, as well as an attempt to understand the therapist's statement, some degree of identification with the therapist in terms of attempts in self observation and observation of interpersonal relationships are also manifested. As the therapeutic alliance appears, the therapist may feel a relief of tension in his rapport with the patient, a surge of enthusiasm and hope. The patient's difficulty in developing the therapeutic alliance may be due to his inability to trust, his difficulty in verbal communication, his general degree of disorganization. But it may also be due to the therapist's lack of patientce and his discouragement with the patient's slow pace and regressive tendencies. For chronic psychiatric patients the therapist tends to become an

auxilliary ego. This may lead to regressive tendencies for the patient that are frightening for the therapist.

The absence of therapeutic alliance may range from active refusal to accept therapeutic intervention to the more subtle form of inattentiveness to group members, to therapist intervention, and the group process. The patient may isolate himself and remain silent, daydreaming, or he may go on free associating in an overly talkative and inappropriate way. This is when the therapist may give up and terminate therapy before it has started, taking refuge in the concept of institutional transference. On the other hand, the therapist's work with patients who have already established a therapeutic alliance can help him to be more tolerant of the pace of patients who are in the process of establishing such an alliance or who are not capable of forming it. A concept such as institutional transference may neutralize the guilt, helplessness and even hate that such patients produce in the therapist (8). But if it is generalized to all patients, it may lead to depersonalization of the therapist's work along with feelings of discouragement and futility and a high turnover of staff. It can also be detrimental to the patients who in spite of difficulty in relating, are able eventually to establish a working alliance with a therapist which may lead them towards therapeutic goals such as self sufficiency.

REFERENCES

1. Reider, N.: A type of transference to institutions, Bull. Menninger Clinic, 2: 58-63, 1953.
2. Saferstein, S.: Institutional transference, Psychiat. Quart. 41: 557-566, July 1967.
3. Saferstein, S.: Psychiatric after care in a general hospital: Some basic principles and their implications for community psychiatry, Psychiat. Quart. 42: 751-758, 1968.
4. Saferstein, S.: Institutional transference - further consideration, Disease Of The Nervous System, 31 (7-12) 149-154, 1970.
5. Sampath, H.M., Kingston, E., Dhindsa, B.: Institutional transference and disengagement. Can. Psychiatr. Ass. J. 16: 227-232, June 1971.
6. Lomas, H.: Institutional transference revisited, Bull. Menninger Clinic, 43: 547-551, 1979.
7. Winnicott, D.W.: The maturational process and the facilitating environment, Hogarth Press, London, 1965.
8. Winnicott, D.W.: Hate in the counter transference. Int. J. Psycho-Anal, 29-30: 69-74, 1948-1949.
9. Balint, M.: The basic fault: therapeutic aspects of regression, Brunner/Mazel Publishers, New York, 1979.

10. de Bosset, F.: Core group: a psychotherapic model in an out-patient clinic, Can. J. Psychiatry, 27: 123-126, 1982
11. Greenson, R.: Beyond transference and interpretation. Int. J. Psycho-Anal, 53: 213-217, 1972.
Greenson, R., Wexler, M.: The non-transference relationship in the psychoanalytic situtation, Int. J. Psycho-Anal, 50: 27-39, 1969.
Greenson, R.: The working alliance and the transference neurosis, Psycho-Anal. Quart. 34: 151-181, 1965.
12. Zetzel, E.R.: Current concepts of transference, Int. J. Psa. XXXVII, 369-376, 1956.
Zetzel, E.R.: The capacity for emotional growth, International Universities Press Inc. New York, 1970.

RESEARCH ON INDICATION OF HOSPITALISATION IN PSYCHIATRY

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Hospitalisation in Psychiatry, which succeeded the internment system in the field of marginality and deviation, gave a medical status to madness and is now disputed as it is considered by certain people as ineffective and hawful.

Its aim in the beginning was to give the patient isolation, protection and care in one place only. The mental asylum became the psychiatric hospital. Afterwards, beside the private clinics, the general hospitals have created in the fifties a large number of psychiatric services (there are now more than 110 of these services in France). The number of patients is increasing, they represent now a third of all public hospitalisations.

Since 1972, the sectorial policy enables the reduction of the number and duration of hospitalisation. The result is, that the number of full-time hospitalisation beds necessary for a section of 70.000 residents oscilates between 30 to 70, which means less than one bed for thousand residents.

Meanwhile, accommodation in psychiatric internment system respresents only 15 % of all admissions, while the number of the new out-ptients each year often exceeds 500 per section. New partial time care places are created as well: day hospitals, night hospitals, help through work centers, prctected foyers, therapeutic flats.

This state of structural upset in the way of taking care of mental patients led certain people to think that full-time hospitalisation was not justified any more and suggested the

suppression of psychiatric hospital and services in general hospital. This tendency seemed to inspire the promotors of the Italian law of June 1978.

These radical solutions are obviously influenced by various ideological currents, certain of which even deny the existence of mental disease and stir the interest of government circles as well, as they give the possibility of reducing the even growing costs of health care.

The risk of adopting legal and economic measures which will be revealed as insuitable in the long run, is important unless a revious study is made, based on clinical and epidemiological research on hospitalisations indicated tendencies.

The study we present today deals with this fundamental problem and proposes the consideration of the various determinations of taking decision of hospitalisation which emphazised the semiological, social and therapeutic criterias without neglecting the personal subjective aspects, wich are so important in psychiatric practice.

The C.P.O.A. - Centre Psychiatrique d'Orientation et d'Acceuil, the Psychiatric Center of Orientation and Reception is a consultation, opened 24 hours a day, admitting emergency patients of the Paris Region.

Half of the patients are directed to the center by the general hospital, the other half are sent by their personal doctors, social organisations or come by their own initiative.

After consultation with the doctor at the C.P.O.A., 2/3 of the patients are directed to a public psychiatric hospital. In other cases, the patients are directed to the local mental hygienic dispensary of their district.

It seemed to us that the fact that consultation at the C.P.O.A. is necessarily short and therefore, no follow-up after the decision of the patients admission is taken, can give an interesting opportunity to reconsider the accuracy of the hospitalisation system through a comparative study between observations and observations taken during the patients hospitalisation period.

This study which took place for a duration of a month concerns 700 cases of hospitalisation. The C.P.O.A. doctor and the doctor who treats the patient, both keep a record of their observation of the same patient; 452 answers were given during this period of one month.

The task was to study the indications of hospitalisation through a comparison of the observations of both services based on the same items: social inadequation and therapeutic's criterias, as well as to analyse the different aspects of doctor/patient relationship during a consultation at the C.P.O.A. and the evaluation of the doctor who treats the patient on eventual hospitalisation.

Results

The first results are delivered through a progressively detailed approache.

We shall first base our study on indication given by the receiving service which is more impartial because its observation time is much longer and it has a possibility to elaborate a constructive critic on the C.P.O.A. work on patients who were not admitted there in the first place.

We found out the following diversions:

60 % - justified hospitalisation
35 % - critical
6 % - uncertain.

We gave special importance to the 270 dossiers justified by the receiving service as a way of finding common significant criterias of those hospitalized.

1. On semiological level:
   Three symptoms are noted: depressive state, delirous state and state of anxiety which is predominant. The spectacular aspect of agressivenes and agitation not common in emergency consultation, are quite rare and confirm the idea that psychiatric hospitals are considered as a place of treatment and not as a place of internment.

2. On social adequacy:
   In 39 % cases of troubles of behaviour, a quite vague criteria, one finds a small number of people dangerous for others, most of them seem to be dangerous for themselves and incapable of having any social contact. Lack of family or friends should be mentioned in 25 % of cases. When it exists, family is not always pathogenic, as one would have the tendency to suppose.

3. On therapeutic hypothesis:
   The importance given to chemotherapy nowadays should be particularly noticed and compared to the actual withdrawal of hope in the psychotherapeutic methods. It turned out that hospitalisation in a certain number of cases (37 %) follows an outpatient treatment that failed.

4. We used the material of 155 dossiers of patients hospitalised on critical indications for a comparative study based on common items (semiological, sociologial and therapeutic) and for an analysis of the subjective and objective criteria perceived in the emergency consultation.

   a) The results obtained on the three main items (semiological, sociological and therapeutic) came out, as expected being similar to the results recorded previously but with harmoniously minored scores.

   b) The moment of consultation
   Patients hospitalised on critical criteria do not differ from the general group of patients while on consultation, which take place mostly during the day on weekends, or in their social integration (domiciled or not).

   The only existing difference is in their hospitalisation's nature: 9 % are interned as compared to 19 % among the general group of patients.

5. On a subjective level, a transferial movement established between the patient and the doctor, remained in emergency consultations of critical cases of hospitalisation.

Three associated themes were united at the moment when the decision of the necessity of hospitalisation was taken, they were: the positive attitude of the patients towards the doctor (53 % of the cases) and hospitalisation (58 % of the cases). This attitude has a special meaning as one knows that in 50 % of the cases, the doctors estimate hospitalisation as a less bad solution and not the best one, and that in 16 % of the cases the patient succeeds to impose hospitalisation by his own initiative on a reserved doctor.

This study tried to show that in spite of the various ambulatory treatment methods we have at our disposal, a full-time hospitalisation in a psychiatric service seems often necessary accoring to clinical elements observed: we introduced here a methodology, based on a critical observation of hospitalisation conditions of mental patients in the Paris region. Only the first results are given here and we cannot pretend yet for this reasons to be able to give an exhaustive look at the problem.

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