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

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

S39-4

THE PHARMACOLOGICAL TREATMENT OF PREMENSTRUAL DYSPHORIA

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Five to ten % of all women of fertile age experience a severe form of premenstrual dysphoria (PMD) that markedly reduces quality of life and for which an effective treatment is highly warranted. It has frequently been suggested that a reduction in brain serotonergic neurotransmission may lead to irritability, depressed mood, and increased carbohydrate craving; since all these symptoms are prominent in women with PMD, the hypothesis that PMD may be related to serotonin is not farfetched. Supporting this concept, five different serotonin reuptake inhibitors (SRIs) have now been shown superior to placebo for the treatment of PMD (clomipramine, fluoxetine, paroxetine, sertraline, and citalopram); in contrast, the noradrenaline reuptake inhibitor maprotiline is not effective. The onset of action of SRIs is much shorter when used for PMD than when used for depression; we have hence obtained an excellent symptom reduction in PMD subjects by intermittent administration of clomipramine or citalopram in the luteal phase only. Further support for an involvement of serotonin in PMD is gained by preliminary trials suggesting that the 5HT1A agonist buspirone, the serotonin releasing agents fenfluramine and mCPP, and the serotonin precursor tryptophan may all reduce premenstrual complaints.

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

SEC40. Is the mental hospital still needed?

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

SEC40-1

THE HISTORY AND DEVELOPMENT OF COMMUNITY PSYCHIATRY

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

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

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

SEC40-2

TIME TO SLOW DOWN THE DECENTRALIZATION PROCESS?

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

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

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