[7] Schene AH et al Acta Psychiatr Scand, 87, 1993: 427–4368.
[8] Fenton FR et al. Arch Gen Psychia, 36, 1979: 1073–9.
[9] Stein LI, MA Test. Arch Gen Psychiatry, 37, 1980. 392–7.
[10] Hoult J, I Reynolds. Acta Psychiatr Scan, 69, 1984: 359–372.
[11] Muijen M et al. BMJ, 304, 1992: 749–54.
[12] Merson et al Lancet 339, 1992: 1311–4.
[13] Tyrer P et al BMJ, 299, 1989: 298–300.

HOSPITAL CARE: FROM SUN TO MOON

Matt Muijen. *The Sainsbury Centre for Mental Health, London, SE1 11B, UK*

Mental health services have shown a dramatic shift from being centered around hospital beds to a diversification into many community based provisions, including 24 hour care. This has meant a change in many aspects of hospital care, whether structure, function, staff or patients.

Structurally the number of beds have been reduced very fast over the last decade, and several mental hospitals have closed. Instead, beds are based in smaller units, sometimes in District General Hospitals, sometimes in innovative community settings.

Functionally hospitals are no longer the centre of the service, instead they offer support to community teams. The greater awareness of outcome of hospital stays and its associated cost has meant a drive towards reduction of bed use by setting up community teams. Several British studies have shown that this strategy only works if teams select their clients well, and have control over admission and discharge.

If effective, this strategy leads to a concentration of people with the most severe problems in hospital for short periods. Patient mix is very difficult to care for, with demoralising effects on staff. Numbers and skills of staff have to be increased to deal with this, threatening to nullify any savings. The threat of a 2 tier system, hospital and community staff, also needs addressing.

Finally, patients and carers prefer community care and dislike hospital admissions, provided support in the community is available. However, places of safety are necessary to protect society and patients alike.

The conclusion is that the shift in care requires shifts in thinking. Community care is not simply exchanging beds for teams, but implies a major change of functions for every element of the system. This in turn demands a rethink of staff roles and training of agencies and professions, from the top to the bottom.

COMMUNITY-BASED PSYCHIATRIC CARE WITHOUT BACK-UP FROM THE MENTAL HOSPITAL. A LONG-TERM EXPERIENCE

M. Tansella. *Institute of Psychiatry, University of Verona, Ospedale Policlinico, 37134 Verona, Italy*

The aim of this paper is to present data, collected in South-Verona, Italy, on a long-term experience of provision of community-based psychiatric care without back-up from the mental hospital, which is gradually being dismantled. This was achieved, according to the Italian psychiatric reform, by means of a block on all admissions to mental hospitals after December 1981, without encouraging abrupt de-institutionalisation. A comprehensive and well integrated system of care was implemented in 1978 and is gradually developing since. It provides care (including in-patient care in a general hospital psychiatric ward where all admissions, both voluntary and compulsory take place) to all patients in at-risk population. South-Verona is a mainly urban area, relatively affluent and predominantly middle class, with a low migration rate. The total population is about 75,000 inhabitants. The South-Verona Community Psychiatric Service (CPS), includes a comprehensive and well integrated number of programmes and provides in-patient care, day care, rehabilitation, out patient care and home visits, as well as a 24 hours emergency service and residential facilities (three apartments and one hostel) for long-term patients. A Psychiatric Case Register (PCR), which covers the same geographical area of the South-Verona CPS, started on 31 December 1978 and has been operating since. Also private hospitals and other agencies in the larger province of Verona provide information to the PCR. Case register data as well as results of evaluative studies conducted in the last ten years will be presented. They show that in 1994, as compared with the year preceding the psychiatric reform, compulsory admissions decreased by 80%; moreover the use of psychiatric beds consistently decreased over time and the mean rate of occupied beds (both in public and private hospitals) per day in the last few years was 0.25 per 1,000 at risk. Since 1979 long stay patients (those who stay in hospital continuously for one year or more) are consistently decreasing, while long-term patients (those not long-stay patients who are continuously in contact, for one year or more, with some psychiatric service, not necessarily the same service or only one service, with a gap between two contacts never longer than 90 days) are steadily increasing. Data on clinical and social outcome in different groups of patients show that the South-Verona CPS meets the needs of severely disabled and most disturbed patients and suggest that it is possible to deal with the full spectrum of psychiatric morbidity within a community-based psychiatric service without back-up from the traditional mental hospital.

WHAT IS THE BEST WAY OF DELIVERING MENTAL HEALTH CARE TO THE SEVERELY MENTALLY ILL?

Peter Tyrer. *Imperial College School of Medicine, St Charles Hospital, London W10 6DZ, UK*

Throughout most developed countries there is a revolution in the delivery of mental health care and this is seen most prominently for those with severe mental illness. The hospital, both as a place of refuge (asylum) and as a focus of treatment, is being replaced by other forms of care. This care is loosely described as community care but it is becoming recognised that this terminology is unsatisfactory as there are so many different types of community care, including the judicious use of hospital. The impetus for providing care outside hospital is often felt to be driven by economic rather than clinical pressures but as individual rights and choice become more widespread the social pressures to provide care which is non-institutional are likely to increase.

Studies of alternatives to hospital based psychiatry in Italy, the United States, Australia and the United Kingdom have demonstrated that assertive community based care for severe mental illness is at least as effective and uses fewer beds than hospital-orientated care, and is much preferred by patients. The best model for providing this care is that of a multidisciplinary team working closely together and sharing many of their roles (the skill-share model). The main reason why such a model is not adopted more widely is that training for community care is far behind best practice in the discipline.