LONG-TERM COURSE IN SCHIZOPHRENIA: PREDICTING CHRONICITY FROM A 15-YEARS FOLLOW-UP OF AN INCIDENCE COHORT

D. Wiersma, F.J. Nienhuis, C.J. Slooff, R. Giel, A. de Jong. *Department of Social Psychiatry, University Hospital, P.O. Box 30.001, 9700 RB Groningen, the Netherlands. Tel +3150 3613839 Fax +3150 3696727 E-mail D.Wiersma@med.rug.nl*

Patients suffering from a first life time psychosis of non-affective type were in 1978 included in a 3-year follow up study and investigated again in the WHO coordinated multi-center International Study on Schizophrenia (IsoS) including patients from various centers in Europe, Asia and North America. The Dutch study completed the 15 years follow-up in 1993 and found out that 19 patients (23.2%) of the total cohort of 82 patients could not be contacted anymore, due to suicide (11.0%), migration abroad and privacy regulations (6.1%) and refusal (6.2%). The remaining 63 (76.8%) patients could more or less be fully interviewed. Data on course of illness, symptomatology and social functioning, and needs for care were collected in a standardized way by means of the PSE-10, the Disability Assessment Schedule (WHO-DAS), the Life Chart Schedule, and other for this project tailor-made schedules. Course of illness and functioning [1,2] will be described in terms of number and length of episodes of psychosis, incomplete (negative syndrome vs neurotic syndrome) and complete remission, and analyzed in relation to spells of in- and outpatient treatment or no treatment. Chronicity and (time to) relapse after each consecutive episode has been analized by means of cox-regression with predictor variables at time of onset of first psychosis (age, sex, education, marital status, premorbid functioning, employment, onset of psychosis, initial diagnosis schizophrenia vs other reactive psychosis). The predictive power — in terms of time in psychosis, partial or full remission — of demographic, illness and treatment variables at onset of the illness was very limited. Insidious onset and delays in mental health treatment are 'risk' factors, predicting a longer duration of first or subsequent episodes. The factor of mental health treatment is probably subject to change because an early warning and intervention strategy could prevent too much damage and further deterioration. Our data support the need for an adequate relapse prevention programme as a priority for our mental health services.

[1] Wiersma D., Nienhuis F.J., Slooff C.J., Giel R. & Jong A. de Assessment of the need for care 15 years after onset of a Dutch cohort of patients with schizophrenia, and an international comparison. Soc Psychiatry Epidemiol 1996 31: (in press)

[2] Wiersma D., Nienhuis F.J., Slooff C.J., Giel R. & Jong A. de Natural course of schizophrenia over 15 years of a Dutch incidence cohort. 1996 (submitted)

S32. Mental hospitals — a thing of the past

Chairmen: G Harrison, M Ruggeri

THE NEED FOR MORE PSYCHIATRIC BEDS: A NEOALIENIST PERSPECTIVE?

Jeremy Coid. *Senior Lecturer in Forensic Psychiatry, Medical College of St. Bartholomew's Hospital, London*

The status of psychiatry as a medical discipline is currently low. Progressive bed closures make it increasingly difficult to deliver service in many areas and have led to widespread but unacknowledged splits among professionals over their personal philosophy of care. Bed closures have been achieved partly through the demonisation of institutions and the perpetuation of myths such as "institutionalisation", the notion that catchment area services can run safely and effectively without beds, and cost savings. Professional attention is now focused on the reality of unlimited responsibility for patients in the community following the introduction of CPA, Supervision Registrars, and the threat of Inquiries following untoward incidents. The question remains over whether a "vision" of community psychiatry can ever be successfully achieved in the context of inadequate and inequitable resource allocation, and heightened but unrealistic expectations of performance from health care professionals.

It is argued that there should now be an open acknowledgement that a large increase in the number of psychiatric beds is urgently needed. Beds should be allocated according to measures of true need. This argument is supported by a review of the literature and recent research findings in secure forensic facilities. A substantial subgroup of patients are identified with conditions which are not readily responsive to contemporary psychiatric treatments and whose challenging and dangerous behaviours cannot be tolerated in the community. Many require prolonged hospitalisation or periods in caring, highly supportive, institutional settings during their lifespan.

IN DEFENCE OF COMMUNITY *AND* INPATIENT CARE

H. Kluiter. *Department of Social Psychiatry, WHO Collaborating Centre, University of Groningen, PO Box 30.001, 9700 RB Groningen, the Netherlands*

The debate and actual choices in psychiatry as to the locus of psychiatric treatment seem to be dominated by ideology rather than by research-based arguments. Randomised studies comparing inpatient treatment to 'community alternatives' (day treatment, home care) indicate that both modalities are needed. Two randomised studies [1,2] have explicitly assessed the degree of feasibility of *day treatment* for unselected *(sub) acute patients* referred for inpatient treatment. Zwerling and Wilder concluded that no more than 39% of their study group could be entirely treated in day hospital. Kluiter et al. found that 61% of their patients could not do without a bed for a substantial period. Five more randomised studies [3–7] compared day treatment and inpatient treatment. In all five studies patients were a priori selected with respect to their being suitable for day treatment. Between 85% and 62% of the patients were (had to be?) rejected for day treatment. None of the randomised experiments comparing *home care* with inpatient care indicate that *acutely disturbed patients* can do without the hospital [8–12]. The care offered in the experimental condition was usually intensive and frequent. Nonetheless the percentages of patients in need of the restrictiveness of an inpatient environment were substantial. In all studies however the average stay in hospital could be strongly reduced, demonstrating that home care and inpatient care can constitute a strong combination. Results from a recent open study by the author show that longstanding home care, closely linked to a hospital, for *chronic patients* is paradoxically far more effective in reducing the number of beddays than stand-alone community care. This finding is in accordance with the results found by Tyrer et al. [13]. (To our knowledge no randomised studies are published covering latter topic.)

The evidence presented strongly suggests that is unwise to abolish inpatient care. And why then abolish (good) mental hospitals where the expertise is?

[1] Zwerling I, JF Wilder. Isr Ann Psychiatr Rel Discipl, 2, 1964: 162–185.
[2] Kluiter H et al Am J Psychiatry, 149, 1992: 1199–1205.
[3] Herz MI et al. Am J Psychiatry, 127, 1971: 107–118.
[4] Washburn SL et al J Cons Clin Psychology, 44, 1976: 665–675.
[5] Dick P et al. Br J Psychiatry, 147, 1985: 246–250.
[6] Creed F et al BMJ, 300, 1990: 291–5.