home support are at least as effective for the patient as traditional hospital care and follow-up, reduce the burden on the family, and are also more economical.

An analysis of the data of the case register of the South Verona Community Psychiatric Service (CPS) on home visiting during a 10-year period (1982–91) will be discussed in the presentation. South Verona CPS is a comprehensive and integrated community-based mental health service where staff members are divided into three multidisciplinary teams, each responsible for a subsector of the catchment area. They work both in the hospital ward and in the community. While not yet offering a 24-hour a day mobile crisis team, the service provides at-home interventions during working hours and ongoing care as needed. Case register data show that while an increase in out-patient community care and day care was taking place over the years, there was a parallel fall in the use of public and private hospital beds. Results of this study show that home-based care increasingly provided in the 1982–91 period to all South Verona patients was associated with a decreasing use of hospital beds. However, differences across age and sex groups appeared: the increase of home-based care regarded older females, but not younger females and males, and was associated with a decreasing use of hospital beds in female patients (all diagnoses) and in female patients with affective disorders and with other diagnoses, but not in those with schizophrenia and related disorders. In addition, the apparent effect of this approach over the years was a distinct improvement of our psychiatric service in terms of workers' clinical skills and therapeutic effectiveness.

COST BENEFIT STUDY OF DAY CARE — THE EFFECT OF AN ATTACHED COMMUNITY PSYCHIATRIC NURSE

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Previous studies have demonstrated that 30–40% of admissions to a psychiatric in-patient unit with acute illness can be treated in a well-staffed day hospital. In this cost effectiveness study, 179 patients with acute psychiatric illness were randomly allocated to day hospital or in-patient treatment. Nearly half the sample had schizophrenia. The groups were well matched on baseline characteristics and clinical and social outcome were similar at twelve months, except that in-patients improved significantly faster than day patients ($p < 0.05$) and burden on relatives was significantly less in the day hospital group at one year ($p < 0.05$). Direct costs to the hospital were, on average, £2,786 (SE ...) per patient cheaper for day hospital treatment compared to in-patient treatment.

Patient travel costs were significantly greater for day patient care and there was a significantly greater loss of informant's income. When all direct and indirect costs were considered, day hospital treatment still proved to be £1,590 (SE = ..) cheaper. In addition to demonstrating that day hospital treatment is cheaper than in-patient care, this study highlights the very considerable distress experienced by carers of people with acute psychiatric illness. This may amount to actual psychiatric disorder in the carer; it resolves more satisfactorily with day hospital treatment than in-patient treatment. By contrast, acute psychiatric disorder appears to resolve faster in the in-patient unit. These findings only apply to those 40% of patients presenting for admission who can be treated in the day hospital and require further study if we are to define optimal use of day and in-patient treatment for acute illness.

FROM EMERGENCY TO SOCIAL PSYCHIATRIC SERVICE CENTERS; THE AMSTERDAM EXPERIENCE

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Outreaching emergency psychiatry has been the keystone in Dutch mental health to prevent admissions in mental hospitals. There was comprehensiveness of acute service with its strong connection with pre- and aftercare. The expansion of the ambulatory mental health centers (RIAGG's) in the eighties, now serving 3% of the population, resulted in a disconnection of the acute services from continuity of care for chronic patients in the community. The mental hospitals in reaction to the ambulatory expansion have set up acute wards to admit patients as short as possible. This policy was viewed as a 'principle' of community mental health care. The unforeseen result was however an enormous increase of 100% in ten years of the number of admissions. The setting up of social psychiatric service centers with continuity of care, tailored treatment, partial hospitalization and related to sheltered living arrangements and day-activity centers for a catchment area of 100.000 are the new solutions to offer in- and outpatient acute care again related to the principles of continuity. From research it became clear most outreaching services could be better viewed as a repetition of interventions for chronic patients. Continuity of care is now seen as the tool to counter the need for acute care. In Amsterdam 5 Social Psychiatric Service Centers are operating, replacing the old hospitals and offering ambulatory and inpatient care.

TENSIONS AND CHALLENGES IN THE PROVISION OF EMERGENCY MENTAL HEALTH SERVICES

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Inevitable conflicts arise when trying to provide emergency mental health services. As a result patients often do not have a smooth pathway into care, and crisis services receive fierce criticism from service users. Difficulties facing those responsible for the provision of emergency care include: lack of any agreed definition of what constitutes a psychiatric emergency; rising demand as services become more accessible and less stigmatising; economies of scale forcing out of hours services to be centralised and anonymous; limited multidisciplinary working and a lack of senior staff working with people in crisis. Numerous models of emergency care have been demonstrated to be effective in specific settings. To provide effective routine services it is essential that there is close integration between emergency services and other aspects of the local community services, and that services are planned on the basis of the needs of the local population, rather than applying a universal model of care.

S35. A new paradigm: psychiatric disablements

Chairmen: C Pull, T Ustun

DISABILITY IN THE GB SURVEYS OF PSYCHIATRIC MORBIDITY

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Data will be presented from the GB surveys of psychiatric morbidity,

https://doi.org/10.1016/0924-9338(96)88545-2 Published online by Cambridge University Press

encompassing household, institutional and homeless samples, on the disability accompanying psychiatric morbidity, particularly in relation to social and economic funding.

Only 39% of adults with a psychiatric disorder are working, compared with 56% of adults with neurotic disorder and 71% of adults with no psychiatric disorder. Compared with the general population, adults with neurosis are twice as likely to be receiving Income Support and four to five times as likely to be on Invalidity Benefit; and adults with psychosis are three times as likely to be receiving Income Support and eight to nine times as likely to be on Invalidity Benefit. The median gross weekly income of people with psychosis or with neurosis is £90, compared to £150 for the general adult population in 1993.

40% of adults with a psychiatric disorder had a difficulty with an activity of daily living, compared to 32% of adults with a neurotic disorder and to 12% of adults with no psychiatric disorder.

THE DEVELOPMENT OF EUROPEAN STANDARDS AND ASSESSMENT INSTRUMENTS FOR PSYCHIATRIC DISABLEMENTS

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Diagnosis is not the sole useful indicator both in clinical practice and psychiatric research as well as in research in health care and the needs of people suffering from mental disorders. The assessment of disablement can be useful in: a) developing better policies for interventions at individual, regional and national level, b) improving the measurement of outcome of mental health care, c) designing optimal management strategies for the mentally ill and d) improving the descriptions of mental disorders. However, although the assessment of psychiatric disablements has been recognized to be of great importance, relevant data are very rarely recorded. Furthermore, there is a lack of common definitions on the concept of disablement. Therefore, very often the data recorded on the assessment of disablement of the mentally ill are very often incomparable. The development of the ICIDH by the WHO in 1980, has been a step forward in this respect and the Council of Europe and individual researchers and agencies have accepted it and promoted its use within Europe. Nevertheless, although a great number of instruments for the assessment of psychiatric disablements has been developed and used in Europe, they are not based on common and agreed definitions such as those provided by the ICIDH. The development of the revised edition of the ICIDH by the WHO, offers a great opportunity for developing common European standards and related assessment instruments for psychiatric disablements. A common European effort for developing culturally sensitive standards and assessment instruments for psychiatric disablements, based on the new international classification of disablements, is urgently needed.

PRACTICAL APPLICATIONS OF ICIDH

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The International Classification of Impairments, Disabilities and Handicaps (ICIDH) was published by the World Health Organization in 1980 as a tool for the classification of the consequences of disease and of their implications for the lives of the individuals.

After 15 years of use, the W.H.O. is undertaking the revision of ICIDH. The Division of Mental Health is charged with coordinating the revision process. The revision process aims to develop a detailed classification system for disablements, which will carry detailed descriptions and clinical guidelines.

The dissemination and application of the ICIDH will be accompanied by important changes in the way impairments, disabilities and handicaps, and the various problems that may arise in each of the three areas are perceived and addressed. It is hoped that the classification will allow a better description and facilitate the assessment of people with disabilities and of their situation within a given physical and social environment.

According to a general principle that applies to the definitions of all the disorders in Chapter V (F) of ICD-10, interference with the performance of social roles, either within the family or with regard to employment, is not used as a diagnostic guideline or criterion. An additional aim of the revision process for ICIDH is to complement the ICD-10 by providing a comprehensive way for assessing the clinical significance of a mental disorder.

The practical implications of the current version and the aims of the future ICIDH will be discussed.

S36. Life events, corticosteroids and cognitive failure

Chairmen: IN Ferrier, DDR Williams

STRESS, CORTICOSTEROIDS AND NEURONAL ACTIVITY: EFFECTS OF EARLY LIFE EXPERIENCE

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A fundamental question in stress research relevant to psychiatry is why life events precipitate brain disorders in some individuals, while others under similar conditions are not affected. To understand these individual differences in susceptibility to stress pathology the role of stress hormones in the interaction between genotype and environment. Genes need to be regulated and corticosteroid hormones secreted after stress are extremely important for this purpose. Genes potentially acting as risk factors for cognitive failure (corticosteroid receptors, apolipoprotein E and amyloid precursor proteins variants) are presently studied in our laboratory in various mouse mutants.

Corticosteroid hormones readily enter the brain and bind to high affinity mineralocorticoid receptors (MR) and lower affinity glucocorticoid receptors (GR) which act as gene transcription factors. Low levels of corticosteroid predominantly occupy MR, while stress levels occupy progressively also GR. MR and GR are abundantly co-localized in neurons of hippocampus, a brain structure involved in regulation of mood and cognition. MR and GR coordinatively control specific gene networks in hippocampus neurons. The gene products are involved in regulation of calcium homeostasis and transmitter responsiveness, which we found to change concomittantly to the steroid effects on behavioural reactivity and cognitive functions.

Recent research in rodents has shown that the corticosteroid tone and the number of hippocampal MR and GR during adulthood are influenced by early life experience. For instance, 3 days' old rats exposed for 24 h to maternal deprivation display as adults hypercorticism and downregulation of GR. The responsiveness to dopamine agonists is increased and the rats appear more susceptible to stereotypic behaviour. In-depth analysis of this phenomenon revealed that the outcome of separation procedures for later activity of the stress system depends on the age and sex of the pup as well as the duration and post-natal time point the deprivation from the mother has occurred.

https://doi.org/10.1016/0924-9338(96)88545-2 Published online by Cambridge University Press