Managers and politicians will only take clinicians seriously when we ourselves have agreed common meanings for these frequently used terms. Only then will they understand the reason for our campaigns and our lobbying for better facilities and more resources for this neglected group of patients. They will no longer be able to take refuge in even more White Papers destined to the same fate as the previous ones on this theme.

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Italian psychiatric care: an update

Following the new mental health legislation, Italian psychiatric hospitals ceased to take new patients after 1980. Long-stay patients were allowed to remain, but are gradually being reintegrated into the community. Meanwhile psychiatric consultants are allowed to have 15 beds per 200 000 population within general hospitals to cater for acute emergencies.

When the reform became law, the 19 Italian regions were left to deal with the planning and setting up of their own community services. Each region has a different political and economic structure which can at least partly explain the regional variations in the psychiatric services found in various studies[1]. These differences have also been made greater by 'the centres of excellence' which have always set standards of care in any health service. In this respect it is worth noting that the major thrust of community psychiatry, fostered by so-called 'Democratic Psychiatry' took place in certain parts of Italy (ie Gorizia, Trieste, Arezzo, Perugia and Ferrara) well before the 1978 Law. In these areas the political involvement of the local administrators, mental health workers, and population at large prepared the ground for radical reform and a more rapid development of community services. Moreover that which at the beginning was a movement of ideas amongst a few became rapidly a well informed movement of opinion and political action[2].

In Italy the provision of psychiatric services is a political issue and so it is not surprising that both fervent supporters and detractors have studied and written about the system.

A recently published book[3] and several articles[4-8] have praised the courage of the reform. However, other authors[9-12] have pointed out shortcomings, criticized the scanty epidemiological evidence, and questioned whether similar reform would be applicable in other countries. But research findings are only one factor among many which determine shifts in psychiatric care[13].

While mental illness is a problem in all countries, its manifestation and modes of treatment vary widely according to the culture of the individual country. The Italian reform should be viewed more as a major turning point in the national philosophy of social and health care, rather than concerning only mental health care. We are dealing more with a cultural reform than just a new organization of services[14].

Italy is a country of contradictions and variety, thus it would not be difficult to imagine that such a radical reform would not be acceptable to all the Italians, let alone to foreigners.

How can we then try to put into perspective the 10-year-old reform, which, in spite of several misgivings, is now beginning to show some results?

A realistic picture of recent Italian psychiatry has been given[15], which still found both old and new patterns of care in different parts of the country. The data, collected from the National Statistical Institute, shows a number of interesting points: there was a steady decline between 1970 and 1985 of inpatients in public hospitals from 0.17% per total population to 0.05% and in private hospitals from 0.04% to 0.025%; the private beds are unevenly distributed throughout the country with a tendency to find a greater concentration in those areas where there have been less enthusiastic provision of community care; in 1984 the total number of hospital patients was 50 000, of which 80% were voluntary admissions, throughout the country with an average length of stay of 12.8 days. There are few elderly mentally infirm included in these statistics as they tend to be cared for outside the psychiatric domain. This makes it difficult to compare these figures with those from

0141-0768/89/080452-02/$02.00/0
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other countries where this is not so. There seems to be a higher proportion of upper class users than before which might be an indication of the lowering of psychiatric stigma.

Another study[16] has demonstrated that chronic patients who have been able to be transferred from hospitals to outpatient community facilities have needed an average of three years of care; a far shorter time than they would have spent within large psychiatric hospitals.

Some of the innovative steps have been collated by Ramon[3]. All the psychiatric hospitals closed have been converted for community use such as group homes, schools or cooperatives. The outpatient clinics, now called Mental Health Centres, have been deployed in the community. They represent the cornerstone of the new system in that they function in a very informal way providing ad hoc therapies, day care, recreation activities as well as long-term solutions such as housing and hostels, though the latter is still far from satisfactory[17].

Rehabilitation cooperatives, cultural associations, workshops, counselling services and relatives' pressure groups are mushrooming, obtaining more and more support from the public and the local politicians, and informal and voluntary organizations are now seen as having professional status. Such a trend can now be seen in UK where GPs are increasingly turning to other mental health care professionals such as nurses and counsellors for help with mental health problems[18].

There are important and useful lessons that can be learnt from the Italian reform[19]: (1) Planning and implementation of adequate alternative structures must be provided before the closure of mental hospitals (this well acknowledged point has been recently emphasized[20]). (2) Regional and local, political and financial commitment are vital prerequisites. (3) Detailed epidemiological evaluation should precede any planning. (4) Primary care should be in the forefront of any community psychiatric care.

To conclude it is true that an epidemiologist from Mars[21] could prove invaluable to help with the figures, but we will all still have to grapple with political and cultural context. Consequently it would seem arrogant to foreclose on a reform that with all its failings, has enabled us to think.

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Male erectile dysfunction

Significant advances have been made in the diagnosis and management of impotence in recent years. Almost all impotent men, if sufficiently motivated, can be effectively treated. The single greatest development in this area of andrology was the discovery by Virag in 1982 that papaverine, a non-specific smooth muscle relaxant, when injected directly into the corpora cavernosa of the human penis produced an erection. The development of successful self injection programmes of a variety of vasoactive agents has revolutionized the management of impotence and greatly simplified the investigation of erectile failure. At the time of this discovery the basis of investigation of erectile failure was to determine whether the patient had psychogenic or organic impotence and relied mainly upon the monitoring of nocturnal penile tumescence (NPT). In patients with psychogenic impotence nocturnal episodes of spontaneous erections occurred during periods of REM sleep. In patients having an organic aetiology these were either absent or impaired. Many units also employed visual sexual stimulation (VSS) to test the patient's ability to produce an erectile response.

0141-0768/89/080453-02/$02.00/0
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