the strike by 10 per cent. During the same period the general wards of the hospital—medical, surgical, geriatric and obstetric—were able to reduce their bed occupancy from 776 to 625: a drop of about 20 per cent. It is of interest that a smaller proportion of psychiatric beds are used for non-life-threatening conditions than general beds.

Admission rate

In the two months prior to the strike the average weekly admission rate had been 20·1 (S.D. = 4·1). During the strike it proved possible to reduce this by one quarter, for the average weekly admission rate was 15·1 (S.D. = 3·2). In the week immediately after the strike had ended, the admission rate rose to 26 and dropped back to normal over the course of the next month.

Mean duration of stay

The patients who were prevented from being admitted because of the strike would presumably have been short-stay patients, since the mean duration of stay during the strike increased from 40 days to 49 days. It took 7 weeks for the mean duration of stay to return to its previous level.

Comment

It would appear that one quarter of our admissions, but only 10 per cent of our beds, are accounted for by conditions of limited duration which are not life-threatening. The remainder of our beds are occupied either by life-threatening illness or by patients who are unfit to be discharged into the community because of the severity of their disabilities. Much of the value of the figures given depends on the rigour with which individual clinicians applied the criteria concerning risk to life or permanent injury to health. In the author's unit we did not discharge a patient if we thought there was appreciable risk of suicide, although we did discharge some patients several weeks earlier than we would otherwise have done, and some psychotic patients were discharged to be managed at home even though we thought hospital care would have otherwise been in their best interests. Most of the patients admitted during the emergency had either attempted or threatened suicide, and the admitting doctor thought that there was a real risk of suicide if the patient was not admitted.

Despite the reduction in admission rate and bed occupancy the work load for the clinical teams was if anything increased during the strike, with additional pressures on our out-patient department and day hospital. The findings seem to indicate that in a modern psychiatric unit in a general hospital the vast majority of patients need to be where they are.

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DAY HOSPITALS' FUNCTION IN A MENTAL HEALTH SERVICE

DEAR SIR,

I must accept very largely the criticisms of assessment and follow-up procedures in my study of 'A Day Hospital's Function in a Mental Health Service' levelled by Drs. Carney and Sheffield (*Journal*, August 1973, p. 250). At the same time, it may be a little ungrateful of them to chastise a caterpillar for failing to be a butterfly: within its limits the poor creature was doing its best.

Perhaps I can clarify the apparent contradiction about widening the scope of day hospitals on the one hand, and being more selective regarding psychopathic personalities on the other. It appears that to date most day hospitals have limited the types of patients treated, either deliberately setting up a programme (e.g. for the senile, subnormal, or adolescent) or unthinkingly selecting or accepting the sort of patients conventionally felt to be suitable (e.g. the chronic psychotic and neurotic, or the convalescent). But it is my contention that a day hospital which is well-staffed, has access to emergency beds, and has good links with community agencies, should be able to offer a superior service for a wide range of patients requiring active treatment who otherwise might have to be admitted to a mental hospital or psychiatric unit as in-patients.

It is also my belief that a proportion of so-called psychopaths are rewarding to treat if a suitable treatment milieu is engineered for them, e.g. the confrontation and support of peer groups in a therapeutic community. However, at the beginning of the Day Hospital at the Ross Clinic, because of a reluctance to antagonize colleagues referring patients to us, we accepted patients with personality or character disorders who were not only not amenable to treatment but also caused considerable disruption in the unit. For some time now we have tried to be more selective with this category of referral.

Of course, this raises the important question posed again by Drs. Carney and Sheffield: what classes of patient are likely to benefit? It seems to me that traditional diagnostic categories are of small assistance, and my own experience often suggests that conventional guidelines can usefully be ignored. But

this merely raises further questions such as: what is it in the treatment programme that is essentially therapeutic for those individuals who do benefit?

We have made further studies in these areas, although some of our results are tentative and even a little confusing. One investigation I carried out in collaboration with Dr. Norman Macaskill involved reviewing the data of 254 consecutive admissions to the Day Hospital during the period 1969/71. This revealed results somewhat different from those of my original study (*Journal*, March 1973, *122*, 307) and no doubt implies some changes in our treatment regime generally. In summary, we showed that age, sex, marital status, social class, and intelligence did not appear to affect treatment outcome significantly. A wide variety of diagnostic categories were treated successfully, and results for schizophrenic disturbances and for patients with personality disorders compared favourably with those for other diagnostic categories (see Table). Referral following a suicidal attempt

TABLE
Diagnosis and outcome among 254 admissions

Category	Per cent patient population	Per cent treatment effective
Depressive neurosis	34	65
Manic-depressive psychosis ..	9	57
Anxiety neurosis	24	73
Schizophrenic disorder ..	3	63
Personality disorder	23	71
Alcoholism	2	60
Other	5	83
Overall	100	68

carried the poorest prognosis, but members of this group who benefited seemed to do best with family and/or individual therapy in conjunction with the standard treatment regime. Total duration of therapy emerged as a significant variable. Discharge at less than four weeks was associated with a poor outcome, and patients remaining in treatment for 9 to 16 weeks did best. Previous episodes of mental illness did not affect treatment outcome.

I suspect that findings such as these, which concern clinicians day by day, and the problems underlying them, will be illuminated not so much by large scale sophisticated studies as rather by the unremitting attention of a large number of modest investigators. Research is not an esoteric activity; but many psychiatrists are inhibited from evaluating their own clinical practice because of an absurd but well-fostered notion regarding what is 'scientific' or acceptable for publication. My colleagues and I continue to nibble away in our corner of the cabbage patch and may yet provide a butterfly or two.

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SERVICES IN THE COMMUNITY FOR THE MENTALLY ILL

DEAR SIR,

I agree with much of Dr. Burkitt's letter (*Journal*, July 1973, 131), but would like to go considerably further. There is increasing concern that the new District General Hospital Psychiatric Units will be inadequate to cope with the demands placed on them and that their introduction as a national policy has preceded sufficient evaluation (Wing, J. K., 1971; Fryers, T., 1973a, b).

As the target of 0·5 beds per 1,000 is approached, more and more of the burden of residential care will be placed on the non-hospital part of the service. Yet in so far as the former will continue to have as its priority the treatment of the acute psychiatric patients, resources will be concentrated on the hospital at the expense of the non-hospital service. A further limitation of hospital units is that their environment is anti-therapeutic in many ways for the majority of psychiatric patients, whose needs are quite different from those of the physically ill—though proper screening to exclude physical illness is of course important (Johnson, D. A. W., 1969).

I would therefore suggest a modification of the current policy: (1) that hospitals should continue to be responsible for the organically ill psychiatric patients; (2) that the non-hospital part of the service should take responsibility not only for the care but also for the *treatment* of the functionally ill. Many policy documents have stressed the need for a comprehensive and integrated system of care. To make an integrated community service requires hospital and non-hospital parts of the service to have equal status. Standards of care seem to be correlated with the degree to which patients are considered to be interesting to doctors. To draw the acute functionally ill patients into the non-hospital based service will draw doctors and other staff there; other resources will follow. Without such a change in emphasis, the so-called 'community' service will become in ten years the equivalent of the old back wards of the large mental hospitals.

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