Prince William?

The future of all large mental hospitals rests in the lap of the gods, or perhaps, more accurately, in the lap of the politicians. In the present political climate there is an inexorable drive towards their closure, the belief being that "community care" – more of a resounding talismanic slogan than a positive fact – will take over the functions of the mental hospitals. So far Horton has been spared and continues to flourish. If the politicians wake up in time to the reality that "asylum" – using the term in the way that it was intended to be used, that is, as a refuge – will always be needed for the chronically mentally ill, Horton will survive.

If it does, may we, in the future interests of historical continuity, look forward to a visit at some time in the future from HRH Prince William?

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Conference briefing

Alternatives to 'community care': the use and misuse of the acute admission ward*

JOHN L. COX, Professor, School of Postgraduate Medicine, Keele University; Chairman, General Psychiatry Section, Royal College of Psychiatrists

This meeting stretched the College facilities to their greatest extent by accommodating 120 general adult psychiatrists on site. The contributions reminded participants that most psychiatrists *have* beds, and that attention therefore needs to be given to the optimal integration of these into an overall psychiatric service.

The implications of the Reed Committee report for general and forensic psychiatrists were highlighted by Dr Michael Harris, while Dr Christine Dean presented new material from her earlier work describing the characteristics of those patients who *were* admitted to beds in multi-cultural Sparkbrook. Dr C. Littlejohns from Clwyd, North Wales drew on his experience as a higher trainee, and spoke on the importance of tempering innovation with experience when managing a rapidly changing service.

Some presentations described the variety of service models on offer, many of them promoted by committed consultants responding to consumer demand. The need for careful evaluation of these innovations was underlined by Professor Francis Creed in his paper on the research methodology of controlled studies.

The drive to develop community services and the perceived threat of a reduction in acute beds with a consequent increase in the proportion of disturbed and detained patients were highlighted by several speakers. These latter developments, as Professor J. Watson pointed out, led to in-patient wards becoming an increasingly less attractive environment for patient care. Dr M. Harris suggested that an optimum in-patient unit might consist of patients with neurotic or personality disorders, as well as those with a psychosis – an option which became increasingly impossible in areas of high psychiatric morbidity with few beds, and where community services were vestigial. Dr Dean, on the other hand, felt that a range of services designed to meet differing needs would provide a better service that a ward trying to meet all needs. Professor H. Morgan described

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the splitting that occurs between non-hospital and hospital psychiatry, due both to ideological conflicts and administrative divisions; the polarisation of training and job descriptions between nursing and medical professions was unfortunate and could lead to low morale, or even to avoidable suicides.

'District General Hospital Units; A Flagship for Psychiatry?': this group, suitably provoked by Drs Pullen and Lawrence, faced up to such controversial issues as 'What *was* a District General Hospital?', 'Would a District General Hospital Unit cease to exist when admission facilities were developed elsewhere, and if this occurred, what were the consequences for liaison psychiatry, and for the education of medical students? Dr Pullen's core message was that admission to a psychiatric unit should be a therapeutic experience in its own right and not merely as a means to deliver physical or psychological treatment.

The seminar 'Psychotherapeutic Treatment on the Acute Admission Ward' featured Dr Jeremy Holmes' paper 'Making In-patient Psychotherapy Relevant for the General Psychiatrist'. Dr Holmes approached this experience as an acute general psychiatrist and psychotherapist. He convincingly described the "unconscious life of the ward" and its dramatisations and splittings. Dr Murray Jackson provided a European perspective, and suggested that psychotherapy with psychotic patients (mostly in parallel with medication) was mainstream general psychiatry within some Scandinavian countries. I outlined the use of large and small groups on an acute admission ward and drew attention to their use for multi-axial diagnoses, eliciting psychodynamic constructs observing patients' progress and how they are economical of time. The need for supervision and for brief methods of recording the content and emotional tone of the groups was emphasised.

Dr F. Caldicott recognised that there were multiple types of service which needed to be evaluated; that acute beds were used in a variety of ways depending on the orientation of consultants, and levels of morbidity and that psychiatric services were being pared down to a worrying extent.

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