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further develop services within a well-defined framework. Continuity of care can be retained, if not improved, by ensuring effective interfaces across services.

At least at some stage of their lives, hospital treatment is and will continue to be necessary for many people with mental illness (Shorter, 1997). Acute hospital psychiatry has consolidated as a specialist service because the combination of severity, acuteness and risk that makes a person's admission to hospital necessary can only be managed competently by a matching combination of skills, resources and facilities. We now know that care in the community has not failed – what has failed is the misguided attempt to ignore the importance of hospital care. As if to make up for this oversight, acute hospital psychiatry as a specialty has emerged as a genuine bottom-up response of mental health services to patients' most pressing needs. As the full-fledged in-patient arm at the forefront of a modernised mental health service, acute hospital psychiatry should now be formally recognised as the specialty that it is, as the surest way of implementing accreditation systems, training programmes and ever-improving principles of in-patient care. Standards of care are bound to rise across all mental health services, and the major beneficiaries will be the patients themselves.

Declaration of interest

None.

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Acute in-patient psychiatry: dedicated consultants if we must but not a specialty†

Until very recently, acute and long-term in-patient mental health services have been low on the agendas of professionals, policy makers and research workers, despite the fact that they continue to absorb much of the adult mental health budget. Consultant time has been increasingly devoted to work in non-hospital settings, as first community mental health teams (e.g. assertive outreach, crisis intervention/home treatment and early-onset psychosis) and more recently the new 'functional' mental health teams have expanded. Staff working in in-patient settings have been perceived as of lower status than their colleagues working within community teams, at a time when the levels of disability and disturbance on acute wards are increasing dramatically and, in many areas, bed shortages are resulting in intolerable strain on the in-patient system. Admission is construed as representing a failure of the individual patient or the service, rather than a potentially valuable therapeutic option.

Acute Problems (Sainsbury Centre for Mental Health, 1998) dramatically underlined the poor quality of experience of many people admitted to acute wards. Policy changes, such as the drive towards single-sex wards, the rise of the 'functional' mental health teams and the increasing burden of work for Mental Health Act tribunals (which threatens to become worse with the new Mental Health Act), make the current orthodoxy of a single consultant spanning the community mental health team and its associated in-patient ward increasingly unsustainable. The introduction of home treatment/crisis resolution teams has further increased the level of need among in-patients and the consequent demands on in-patient staff (Ingram & Tachi, 2004).

Solutions?

A move towards a solution to the crisis in in-patient care began with official recognition of the problem, which took the form of policy statements on acute in-patient services and intensive and low secure care (Department of Health, 2002*a*,*b*). Strategies have been elaborated to foster service improvement in in-patient settings, which make use of readily available modernisation tools (Rix & Shepherd, 2003); these strike one as unconvincing unless staff skills are improved in the process. More convincing local initiatives have included the provision of enhanced, dedicated senior medical resource to an acute ward (Dratcu, 2002) and the introduction of a 'triage' unit, again with enhanced senior medical resource, as a single point of entry into a local acute unit (Inglis & Baggaley, 2005).

Acute in-patient care as a specialty?

We are moving towards a new orthodoxy within adult mental health services, which requires consultant time to

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be dedicated to specific elements of an increasingly fragmented service. These elements include acute in-patient care, intensive care, early intervention in psychosis, assertive outreach, home treatment/crisis resolution and community mental health teams (which are also increasingly becoming differentiated). It therefore seems inevitable that some consultant adult psychiatrists will be spending all or the majority of their time working within in-patient settings, during all or part of their career. Does it then follow that we require a new specialty? There are various ways of addressing this question, which range from the metaphysical ('what should constitute a specialty?') to the practical ('what benefit would flow from having a specialty and for whom?').

My answer includes a digression that relates to my own consultant career which, at the time of writing, spans some 19 years. During this period I have been consultant to a mental hospital closure programme, a day hospital, several acute in-patient wards, an out-patient department, an intensive care unit, two community mental health teams, an assessment unit for homeless people, an assertive outreach team, and a rehabilitation unit and community rehabilitation team. I have been on both sides of a job-share straddling a community mental health team and its associated in-patient unit. I have even had to cross recognised specialties and cover a community forensic team, and have provided input into our local teams for early intervention in psychosis and home treatment. This eclectic-sounding clinical career is not the product of occupational instability – I have worked for the same employer throughout, although its name has changed four times – but reflects the range of tasks I have been required to tackle, both as local services have evolved and in response to national initiatives. Without exception, these roles have benefited from the experience I gained in previous and concurrent roles.

When investigating the need for an acute in-patient specialty, an obvious question is whether psychiatric in-patients differ from those who are not admitted. The answer is both 'yes' (because they are more ill at the time and, in inner urban areas, are frequently detained under the Mental Health Act 1983), and 'no' (because there is marked diagnostic heterogeneity among in-patients in the UK, only a minority of whom have psychotic illnesses). They are, by and large, people who are generally cared for by secondary mental health services, but are at a particular stage of their patient journey. A second question might be whether specific skills are required of the acute in-patient psychiatrist. Apart from knowledge of the latest protocol for rapid tranquillisation, and how to remain calm in the face of a mental health review tribunal, it is difficult for me to identify a skill that is specific to the in-patient setting. All adult psychiatry requires good understanding of assessment and diagnosis, mental health legislation, team dynamics, how to work with carers, psychological treatments, the physical healthcare needs of patients and how to mobilise community support.

Conclusion

It is right that, even in this era of de-institutionalisation and avoidance of admission, acute in-patient care is seen as important and is allocated more consultant time. It does not follow that we need to encourage the development of a further specialty within adult psychiatry devoted to acute care. The confusion lies in the distinction between spending all or the majority of one's time on a particular aspect of adult psychiatry, which might require some specific and novel competencies (be it in home treatment, early-onset psychosis, acute in-patient work, etc.) and the elaboration of a separate specialty. What is clear is that consultant adult psychiatrists of today and tomorrow will have to be flexible enough to apply existing skills to ever-changing demands, and to develop additional competencies as circumstances, demands and methods of treatment change.

Declaration of interest

None.

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