after a lifetime of psychiatric practice continue to contribute in retirement to British psychiatry.

This list is by no means exhaustive, but in essence, the best summary is probably that in Ida Macalpine's obituary (C.J.E., 1974): 'she was one of that number of medical men and women who sought and found refuge in Britain from Nazi persecution... and lived to enrich by her achievements the country of her adoption'.

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Recovery-oriented mental healthcare

I commend Drs Lester & Gask (Lester & Gask, 2006) on their excellent and challenging editorial highlighting some of the issues involved in the development of high-quality recovery-oriented mental healthcare. Having begun my medical training in New Zealand, where recovery is heavily embedded into every facet of mental health services (Mental Health Commission, 1998), I have watched with interest the emerging prominence of recovery as a model for services in the UK. I would like to suggest two further avenues that are central to this continued evolution.

The first is to integrate recovery into the training of all psychiatrists. As the editorial rightly states, 'promoting recovery' is seen as an essential capability for all mental health professionals (Department of Health, 2004). We have an opportunity, while implementing the greatest change to modern medical training in the UK to date, to ensure that knowledge and skills in recovery-based practice are core competencies of psychiatric trainees. The current provisional curriculum pays little more than lip service to this crucial component, stating that trainees should be able to 'describe the principles of rehabilitation and recovery' in the context of treating chronic illness (Royal College of Psychiatrists, 2006). If we are to produce psychiatrists with the ability to 'promote recovery', the principles need to be a component of all areas of clinical training as is the case within the development of nurse training in the Chief Nursing Officer's recent and appropriately titled report, *From Values to Action* (Department of Health, 2006).

Second, we need to find methods and tools to meaningfully measure the recovery orientation of our services. There are currently no fully developed tools to achieve this, but the most promising recovery-sensitive measures require collaborative work with service users in their implementation, thus ensuring that the recovery principles measured become a core component of service evaluations, development and research.

As the Royal College of Psychiatrists moves towards 2007, when its annual meeting will embrace recovery as its core theme, I join the authors of this editorial in their call for recovery to play an increasingly central role in all areas of psychiatry.

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One hundred years ago

Hospital and dispensary management. Glasgow District Asylum, Gartloch

FROM the annual report for the year ending May 15th, 1905, of Dr. W. A. Parker, Medical Superintendent of this asylum, we see that there were 683 patients on the asylum register on May 15th, 1905, and that on May 15th, 1906, there were 684. The total number of cases under care during the year was 971, and the average number resident 702.1. During the year 288 cases were admitted as compared with 297 for the previous twelve months. The majority of these were unfavourable cases, because now all the cases likely to recover speedily, transient alcoholic and *delirium tremens* cases, are treated at the mental block of the Duke Street Hospital. Of the total admissions 95 were the subjects of first attacks within three and 24 more within twelve months of admission, in 57 the attacks were not first attacks within twelve months of admission, in 87 the attacks were of more than twelve months' duration on admission, and 25 cases were of congenital origin. Thus 169, or 58.3 per cent., had either been ill over a year on admission, were congenital imbeciles, or had suffered previous attacks, and even of the remaining 41 per cent., Dr. Parker says many were hopelessly senile cases, or general paralytics, or otherwise incurable. They were classified as to the forms of mental disorder into: Mania 49; melancholia 56; confusional, delusional, or adolescent insanity 78; dementia 36; general paralysis 26; epileptic insanity 16; congenital defect 25; and syphilitic and moral insanity each 1.

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