violence in acute psychiatric wards locally by combining Jarman scores and data from annually published figures in the Criminal Statistics of England and Wales. Annual average per cent bed occupancy and nursing staff levels might also have predictive value and an index of these four factors might inform the local need for provision of intensive care or high dependency psychiatric units.

WALKER, W. D. & CAPLAN, R. P. (1993) Assaultative behaviour in acute psychiatric wards and its relationship to violence in the community: a comparison of two health districts. *Medicine, Science and the Law*, **33**, 300–304.

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Home versus out-patient psychiatric assessment

Sir: In South Manchester 50% of all newly referred patients to the Department of Psychiatry fail to keep their out-patient appointments. This is wasteful of medical time, permits mental illness to go untreated, and deprives medical students of valuable experience.

In the second and fourth quarters of 1992 new patients were therefore seen in their homes. In the first and third quarters of 1992 they were assessed in the out-patient clinic. Three new patients were appointed per clinic. In home-based assessments, the consultant took the medical student to the patient's home and introduced the student to the patient. The consultant then went to see another patient and returned an hour later.

Forty-six out of 59 (78%) appointments at patients' homes and 30 out of 55 (55%) appointments at psychiatric out-patient clinics were kept, a significant difference (χ^2=6.01, P=0.014). Home visiting often revealed diverse life circumstances and enabled a friend or relative to act as an additional informant. This aided the assessment of premorbid personality and functioning as well as their social, family and supportive relationships which has special relevance with respect to the care programme approach.

Over 12 months, 14 medical students participated in home-based, and 13 in hospital-based psychiatric assessments. Home visiting did require the use of the consultant's car and driving between six and eight miles an afternoon, which incurred on average an additional 30 minutes per clinic.

In an urban area, therefore, home visiting can lead to more new patients being assessed, and greater efficiency. The rate of availability for assessment was not as high as that found by some community based mental health teams (Burns *et al*, 1993; Jackson *et al*, 1993). However, most patients preferred their initial assessment to be at home and medical students found such assessments more interesting. It is possible to teach medical students psychological medicine in domestic settings as well as exposing them to the concept of caring for people in the community.

BURNS, T., BEADSMOORE, A., BHAT, A. V., *et al* (1993) A controlled trial of home-based acute psychiatric services: I. Clinical and social outcome. *British Journal of Psychiatry*, **163**, 49–54.

JACKSON, G., GATER, R., GOLDBERG, D., *et al* (1993) A new community mental health team based in primary care. A description of the service and its effect on service use in the first year. *British Journal of Psychiatry*, **162**, 375–384.

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How caring is community care

Sir: With the current ethos of 'community care', more of our patients are being seen outside of the hospital and out-patient clinic. In old age psychiatry this can give a deeper understanding of the interaction between a patient with dementia and their environment. It allows us to assess the safety and cleanliness of the home, as well as the patient's orientation and function within it. It also fits the 'politically correct drive' that sometimes occurs with community care.

In Swindon we are fortunate to have a compact catchment area, most of our caseload are within 15 minutes drive from the base hospital. As a consequence 80% of my patients (new cases and follow-up) are seen in their residence.

However, in the last month, three families, on asking have stated their preference for hospital consultations. In two cases it was a break from the daily routine, and in the other the carer felt it would ensure the patient got out of bed early.

I sometimes wonder if our drive for community orientated care runs contrary to the patient's desire. Hence to use the jargon, I have developed a more 'service-user led model of care delivery'.

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Mad poets?

Sir: I feel moved to comment on Hugh Freeman's review of Alex Mezey's book *Muse in Torment* (*Psychiatric Bulletin*, September 1995, **19**, 588–589). In particular, the concluding comment on

Rossini; most music lovers would reach for their *Grove* and confirm that Rossini's operatic output proceeded relatively undiminished long past his twentieth year, up until 1829 when he produced his last opera *William Tell*. Rossini, at the age of 37 years (born 29 February 1792), then went into a creative decline, although he did write his *Stabat Mater* in 1832 which may reflect a growing melancholia at that time. In 1864 he wrote his *Petite Messe Solennelle*, bringing an essentially non-productive period of 32 years to an end, but whether this was due to "the longest mood swing on record" is speculation of the best quality! During this period his wife died (1845) and yet he remarried just two years later. A wealthy man, he hosted superb gourmet dinner parties for eminent musical friends and literati and does not appear to have been particularly depressed during this period. However, a certain instability and laziness of character is recognised, alongside an emotional lability stirred up by nationalistic feelings and a degree of jealousy for the rising popularity of other composers and can be cited as antecedents for depression.

My studies lead me to conclude that Rousseau most likely had an episodic bipolar affective disorder, not 'madness' (schizophrenia), and most of his creative output occurred between episodes. In this respect, I cannot accept him as 'undeniably mad'. I have only confidently identified 15 cases of schizophrenia/paranoid psychosis among creative writers, and most were poets.

Having a personal interest in the psychopathology of eminent deceased persons with extensive data gathered on some 550 famous individuals, I would like to echo the points made by Mezey concerning suicide among major writers. Of 140 eminent creative writers in my series, 56 committed suicide – some 40%, of whom 50 had major psychiatric disorder (mostly affective disorders but a few schizophrenics), two a primary diagnosis of alcohol/drug dependency, and four uncertain psychiatric disorder. Only three of the 50 with major psychiatric disorder had an associated alcohol/drug dependency, which runs counter to expectation.

I would agree with Mezey's principal message in that a detailed knowledge of a writer's psychopathology "cannot *explain* the nature and origin of poetic gifts", but I would go further and say that an understanding of a writer's psychopathology, the emotional tensions and the personality factors colouring the clinical picture, facilitates a better appreciation of both the writer and his/her creative works.

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Consultant manpower (1)

Sir: Regarding severe shortage of consultant psychiatrists, Dr Jarrett's suggestion of increasing the period of permit free training for overseas doctors will not be acceptable to the General Medical Council (GMC) or the Home Office (*Psychiatric Bulletin*, September 1995, **19**, 573–574). In any case, this is unlikely to work as the bottle-neck between registrar and senior registrar posts persists. An increase in manpower approval of senior registrar posts has not worked and is unlikely to be successful in the present economic climate. Also, it will take several years to make a significant impact in reducing consultant shortages.

'Rehabilitation' of 'inadequately trained' psychiatrists may be the only solution in the present circumstances. Many hospitals and Trusts have no choice but to employ such psychiatrists. Certainly it is better to have someone to provide a service than none at all. Many locum consultants are in post for years and have extensive experience, far greater than a new 'adequately' trained consultant. Dr Jarrett is correct in pointing out that the proposal of rehabilitation of such doctors will be resisted by the College and Department of Health but I am not certain what Professor Thompson means by "We can but try". In fact the College itself has used double standards. On one hand, it threatens health authorities and Trusts with refusal to grant approval of such consultants as an educational supervisor and, at the same time, in its Guidance for College Assessors on Advisory Appointments Committees, states that the consultants (inadequately trained) would be able to apply to the College, after not less than one year as working as a consultant, to become an educational supervisor. The College also says that it would be unable to recommend to the GMC that the candidate's name be placed on the specialist 'T' register, yet the College has granted TPsych registration to many inadequately trained consultants. This makes me wonder what this TPsych actually stands for. If these inadequately trained consultants with TPsych apply for another substantive post, would College assessors consider them adequately trained?

The problem of inadequately trained and locum consultants is not a recent one. Azuonye (1990) suggested that locum consultants in continuous employment for four years should be considered for an appointment to a substantive consultant post. I must say a great deal of the problem lies with the College itself in that it has failed to give appropriate advice through its Manpower Committee to the Department of Health, Health Authorities and Trusts as to how to deal with