numbers she produced. I suggest a long drink of cold water.

It seems to me to be a great pity that we should all be agreeing meekly with the politician's diktat that if resources are to be improved in the periphery then this can only be done by allowing services to deteriorate at the centre: we are heading for an NHS that is uniformly under-resourced, with satisfactory conditions only for those in the private sector (who may indeed be middle class, and have relatively minor illnesses). If we dissipate our energy in attacking one another, and no one stands up for a better NHS with adequate resources at both teaching hospital and peripheral unit, we shall have no one to blame but ourselves. And that really would be shameful.

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REFERENCE

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[This correspondence is now closed—Eds.]

Experience of a community-based approach to alcoholism

DEAR SIRS

Intoxication is a maladaptive coping mechanism which disrupts family life, produces a familiar toll of deaths from ill health, injuries on the roads in accidents, in assaults and vandalism and in suicides. For the less disturbed psychiatry will offer re-education in coping strategies which can offer an alternative to intoxication by drink or drugs.

There is difficulty in dealing with these re-educative areas in the Health Service as the most effective treatments involve psychotherapeutic techniques often over long periods of time. Patients with drink and drug problems often need the help of long-term support groups. Relapse may also be frequent and disheartening for both patients and therapists.

The cost of providing manpower for such treatments offered by statutory health authorities is potentially far greater than the cost of the machinery for high technology medicine. Despite the identification of psychiatric services as priority areas for health expenditure, it remains a Cinderella specialty when funds are distributed. Despite the conflict between rising costs and rising expectations for quality of health care there is a popular and therefore political demand to improve these psychiatric services.

One solution is for the NHS to work in close collaboration with voluntary agencies. An example in the field of addiction treatment and prevention is ACCEPT—an acronym derived from Alcoholism Community Centres for Education, Prevention and Treatment. ACCEPT is a charity which operates day centre treatment facilities offering a wide variety of sophisticated psychotherapeutic techniques which would be envied by most psychiatric day hospitals. As part of my higher professional training at St George's Hospital Medical School I have been able to spend time working at ACCEPT's major centre in Fulham, which deals with upwards of 100 new cases per month.

This has been a fascinating experience with several benefits. I have had access to the clients there and have therefore been able to see a much greater range of presentations of addiction problems than that afforded by the patients referred to psychiatric services or even presenting in general practice. I have also learned how to work with the lay and voluntary workers and allow them to make use of my skills and obtain psychiatric advice for their clients. I have conducted group and individual therapy and been able to offer this to people who could not have been prepared to participate in such treatment under a label of psychiatric treatment, but who found attendance at a community agency fully acceptable.

The quality of intervention and its continuity of therapists over time is remarkable and better or equal to that of the best neurosis units in the health service whose numbers are, of course, very limited because of their high costs. I have also been able to gather research data from the client group to further my own interest in addiction problems.

I have found my experience very worthwhile and suggest it would be a useful model for the future. It shows that both training and service functions can be provided by voluntary agencies in co-operation with the NHS and that they complement each other and achieve good results as well as significant financial savings. The experience also brings community involvement in psychiatric care to life with the committed involvement of both sides which is essential for any real success.

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Education in health care of people with mental handicap

DEAR SIRS

In the past most doctors have often received little undergraduate or postgraduate teaching about mental handicap. That they have often been at a loss to help mentally handicapped people has been noticed by the parents of mentally handicapped children. Specialists in Developmental Paediatrics and Child Health have seen an increasing proportion of, but never all, mentally handicapped children. General Medical Specialists treat mentally handicapped people referred to them with particular complaints, but they are not concerned with these patients' lives as a whole.

A need for more teaching of doctors about mental handicap is emerging so that family doctors can help the mentally handicapped more confidently. Continuing specialist help is also required for a variety of problems. Teaching on mental handicap has tended to become a catalogue of relatively rare conditions, but today there is an opportunity to develop teaching more widely as the 'health care of people with mental handicap'.

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Under this heading, first, is the treatment of medical conditions, illnesses and injuries in mentally handicapped people. They may be vulnerable to infections as a result of impaired immunity, to the complications of congenital abnormalities, and to injuries following poor co-ordination or epileptic seizures.

The family doctor has an important role in supporting families with mentally handicapped members. Doctors who have themselves had children with mental handicap have emphasized the need for good personal communication; they stress that parents should be informed as soon as a clinical diagnosis of mental handicap is reached. Positive advice, encouragement and continuing reassurance are essential. Stimulation of a mentally handicapped child is necessary. Regard has to be given to other members of the family. Over-protection has to be balanced against risk taking. The frustration and loneliness of the affected persons and their families need understanding. The family doctor requires a working knowledge of allowances and where help and advice are available.

Second are the special needs of people with mental handicap. A quarter or more have epilepsy. Visual and hearing defects are often present; speech and communication difficulties are frequent. Incontinence, physical disabilities and deformities occur. Many mentally handicapped people need advice about nutrition and diet.

Third is the more specialized subject of the Psychiatry of Mental Handicap, but the family doctor is often the first to meet a problem. Psychoneuroses in mentally handicapped people may become more frequent as more of them live in the community. Psychoses, the schizophrenias, and affective disorders affect a minority and diagnosis may be difficult; organic states, subdural haematoma, cerebral tumours and endocrine disorders, in particular, hypothyroidism, can also arise. Epilepsy may be difficult to control completely and is associated with behavioural disturbances. Dementia occurs in a proportion of people with mental handicap. More specialized problems are those of 'mental impairment'—abnormally aggressive and seriously irresponsible conduct, patients difficult to place because of their dangerous propensities, patients discharged from the Special Hospitals, and mentally handicapped offenders for whom the penal system is inappropriate, but an alternative hard to find.

Fourth are the broader issues of prevention, causation, epidemiology and research in mental handicap. These involve a wide range of medical specialties, but need study as an essential part of the health care of people with mental handicap in the community.

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Artists and psychosis—Methodological issues

DEAR SIRS

The link between giftedness and mental illness remains elusive. Dr Mahendra's excellent review (*Bulletin*, February 1985, **9**, 37–38) indicates that such a link seems most likely in the area of affective illness and hints that family studies are most likely to reveal a (genetic) link. Attempts to procure creative individuals as probands for family study may be the most likely to indicate the presence of affective disorders or schizophrenia. We must echo, however, Dr Mahendra's caution and scepticism in investigating such individuals, and can report considerable difficulty in our own such study. Particular problems exist in the definition of giftedness ,or creativity. Psychometric tests have not provided a useful answer and tend to suggest an equivalence between schizophrenic thought disorder and creativity—or just the opposite. The movement toward social definition of creativity is more realistic and facilitates selection for study. 'Giftedness' or 'talent' tends to be bestowed by social consensus upon those skilled in the performing of fine arts. Thus the existence of giftedness is validated by social recognition and popular acclaim, and may describe different skills in different cultures.

The terms 'gift' or 'talent' in common usage do not differentiate between sensorimotor skills, e.g. instrument playing, and creative thinking, e.g. composing or writing poetry. Often the two seem to coexist, perhaps because each facilitates the expression of the other and separation of the two qualities may be unrealistic.

The question that seems to have been of continual fascination might be put more specifically: 'Are people acclaimed as successful artists likely to have a history (or family history) loaded towards mental illness?' 'Acclaimed artists' can be isolated for study, e.g. Dr Kay Jamison (*The Guardian*, 1984, 24 September) used possession of the Queens Gold Medal for poetry as validation of acclaimed talent in that field. Thus the social process of 'acclaim' defines a study group operationally.

Our study attempted to isolate a population belonging to institutes of national standing in the arts, and screen them with a short standardized questionnaire outlining the talent itself and any personal and family history of mental illness. Initial pilot data showed a 33 per cent return rate. We then wrote to art and music colleges, theatre, ballet and opera companies and symphony orchestras. Altogether we wrote to forty-seven institutions. When only twenty-four replies to our letter were received, and only five of these showed any agreement to participate, we began to worry about the kind of reception psychiatric investigators could expect from artists. Despite considerable persistence, only three institutions eventually distributed our questionnaire (along with pre-paid envelopes and strong written assurances of anonymity).

Altogether 500 questionnaires were given out in three very well known art and music colleges, to both staff and students. To our disappointment we must report an extremely low return rate, thirty-two replies only (6.4 per cent). Many of the replies we did receive expressed considerable suspicion and resistance to concepts of psychiatric illness or research therein. Though such a low return rate precludes useful interpretation of data, we can say that no respondents reported any personal or family history of schizophrenia or any disorder other than affective illness. Six respondents had been treated by psychiatrists for depressive illness and a further one was in analysis. Four only had been hospitalized and only one had had manic episodes. Four of these were musicians. As regards first degree relatives, seven respondents showed a family

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